Healthy Homes and Lead Poisoning Surveillance System (HHLPSS)

Guidance Manual

May 2014

Version 1

Welcome

Welcome to HHLPSS, the Healthy Housing & Lead Poisoning Surveillance System. HHLPSS is a web-based, case management and surveillance application that was developed to help local Childhood Lead Poisoning Prevention Programs (CLPPPs) track, investigate, and follow up on lead poisoning cases. The HHLPSS stores comprehensive data relevant to lead poisoning cases, including patient names, addresses, blood lead results, and follow-up data. Using this data, HHLPSS generates case management letters, alerts, reports and analyses.

HHLPSS
Healthy Housing and Lead
Poisoning Surveillance System

HHLPSS Secure Portal and Login Pages

Once you have completed the instructions for setting up a 4 digit PIN for your token follow the instructions below.

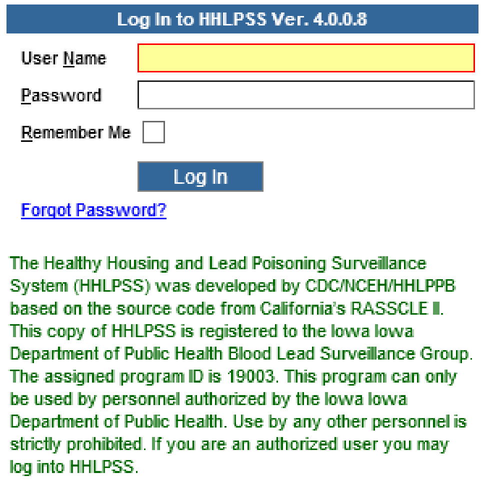
******* If you already have a token and we did not mail you one then you do not need to setup a 4 digit PIN because you already have one.

To access HHLPSS you must visit https://hhlpsstrain.idph.state.ia.us/rii.web/security/login.aspx enter in your Token User name and Token password plus 4 digit pin. Click Log on.

Go to this URL for the **HHLPSS Training Site**:
https://hhlpsstrain.idph.state.ia.us/rii.web/security/login.aspx.

Then you will get the screen below. Put in your token User name and TOKEN Password, plus your 4 digit SoftPIN number. Click the Log On button.

You should get the HHLPSS log in screen. Enter the username and default password from the letter you received with your token. Click Log in.

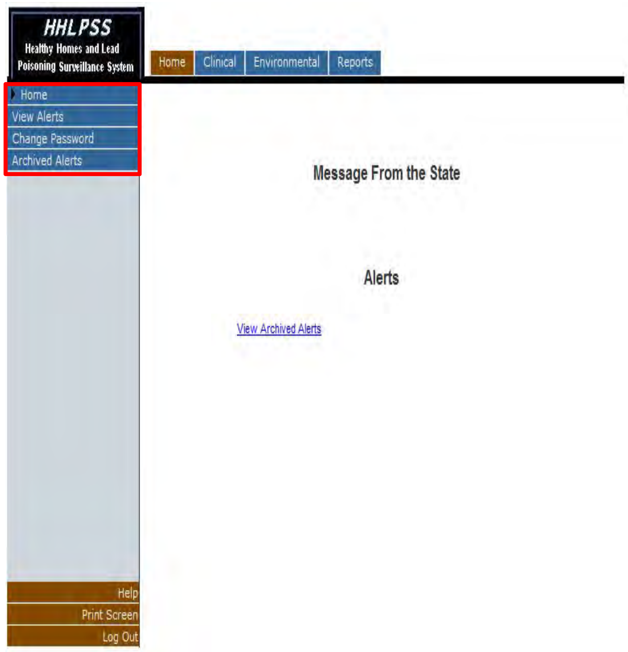


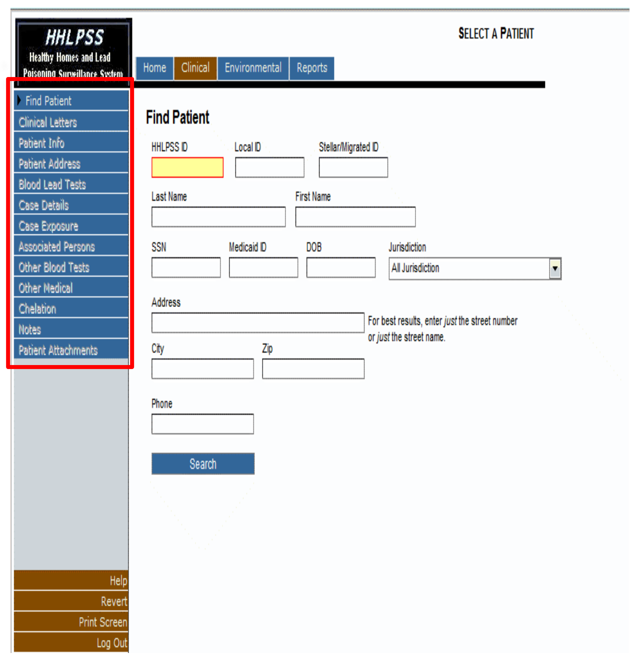
If you have any problems logging into HHLPSS contact the HHLPSS Helpdesk Administrator at:

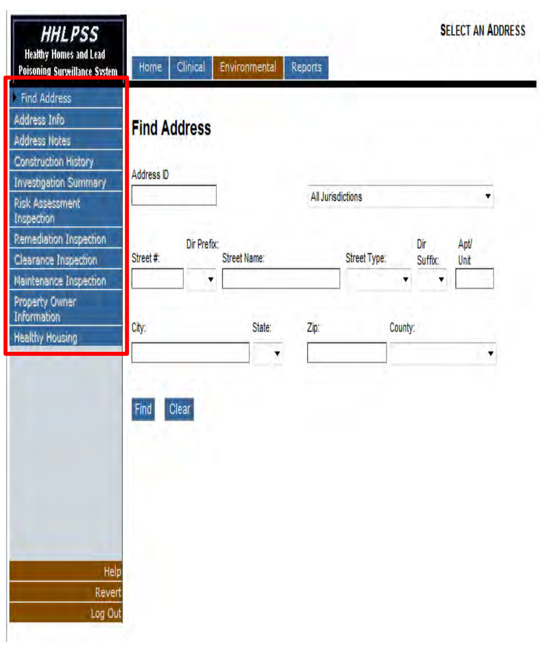
Janet Lemmerman
Direct: (515) 242-5200
Toll Free: 1-800-972-2026
Email: Janet.Lemmermann@idph.iowa.gov

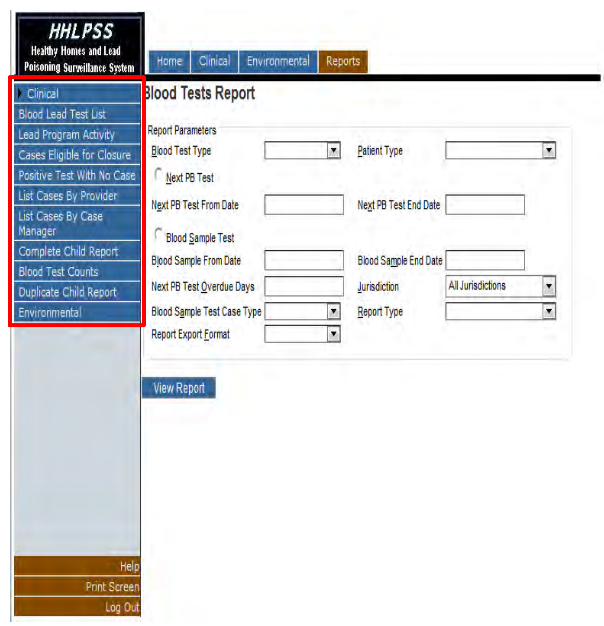
Module Pages

After logging into HHLPSS you will be taken to the Home module page. Module tabs (Home, Clinical, Environmental, Reports) appear at the top of each page. Each tab has a menu of links in the left column specific to the function of that module.



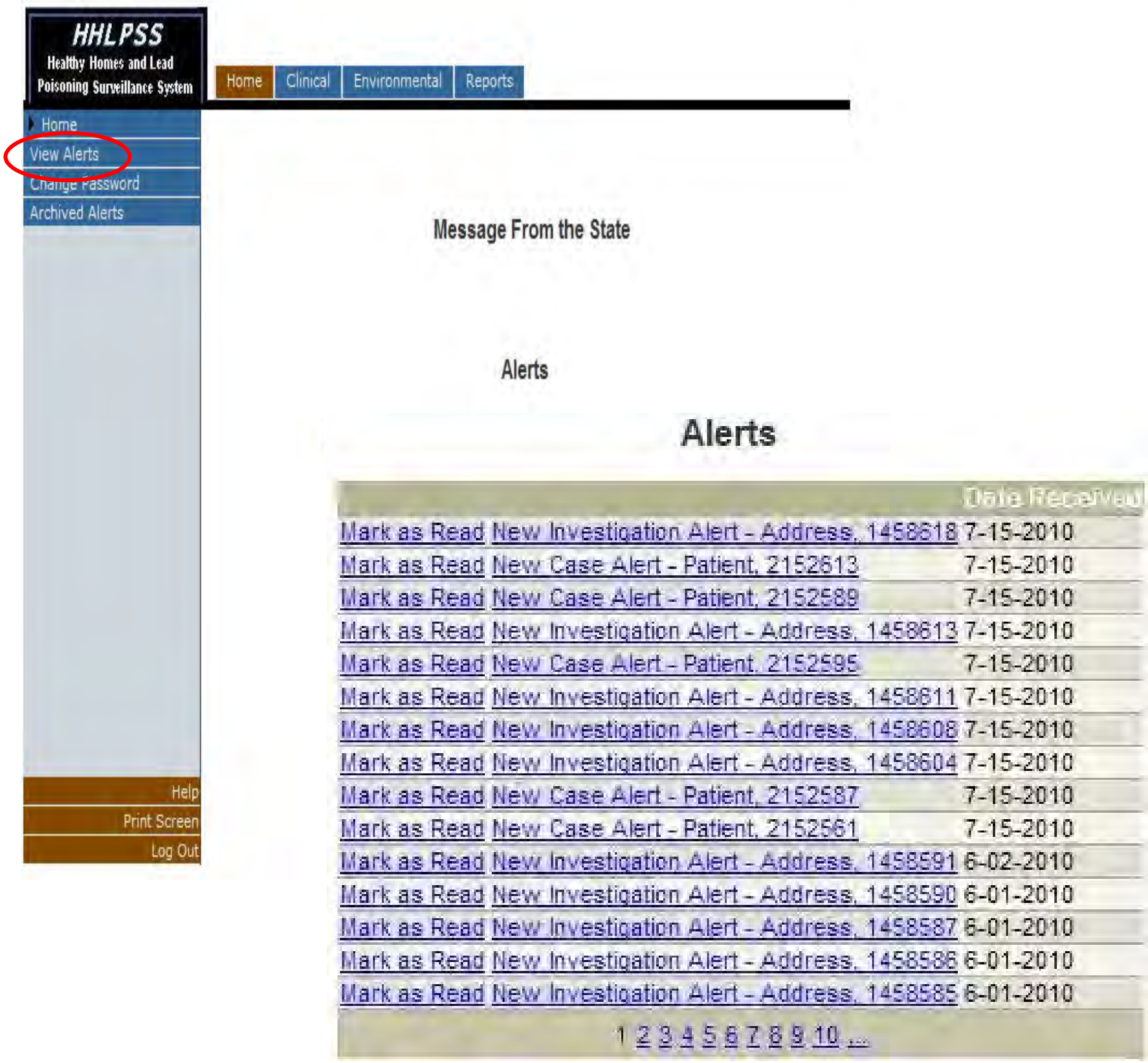






Home Page – *Home Module*

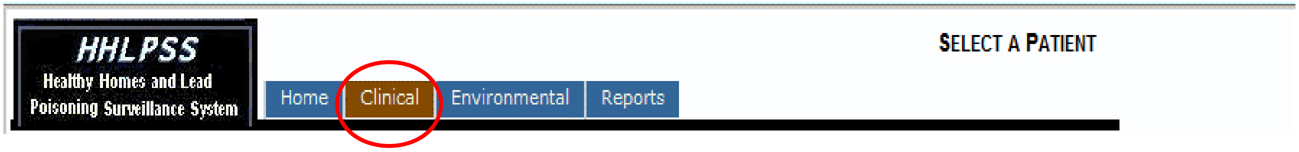
Alerts are generated as events are occur (e.g. Cases created or closed) and are recognized by the system. Users are notified automatically to the occurrence of these events through alerts.



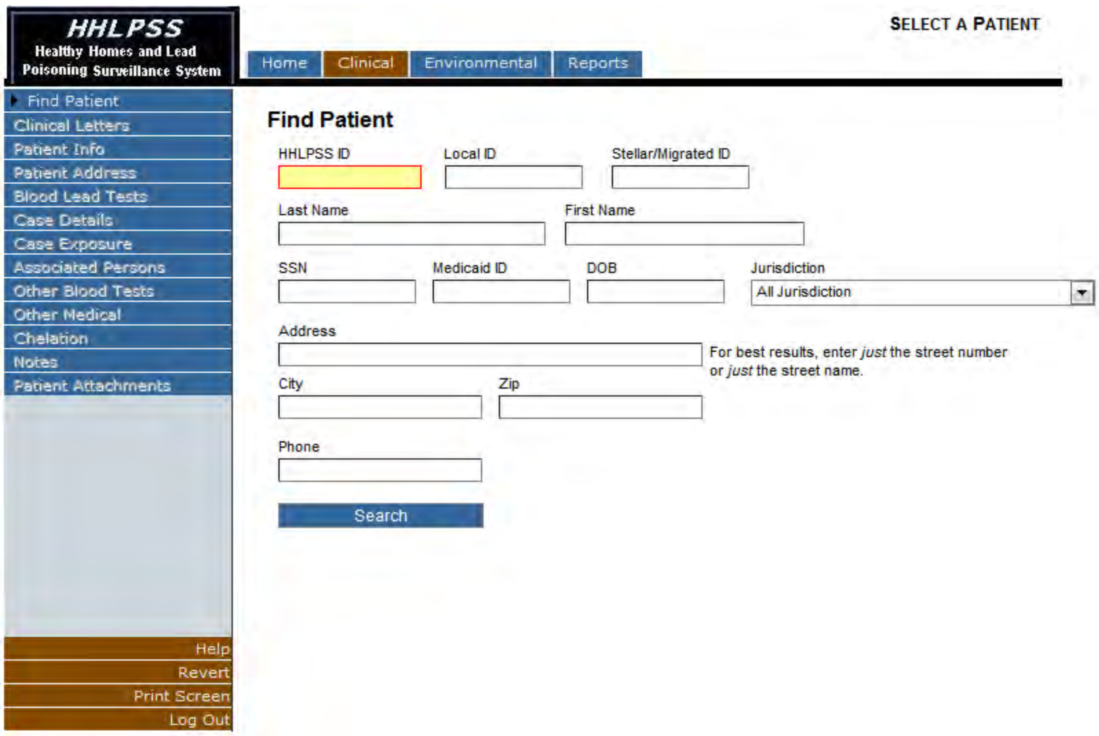
Case Management – *Clinical Module*

The clinical module has been designed for viewing, editing or creating new patient records as well as details related to patient cases.

Select the Clinical tab.



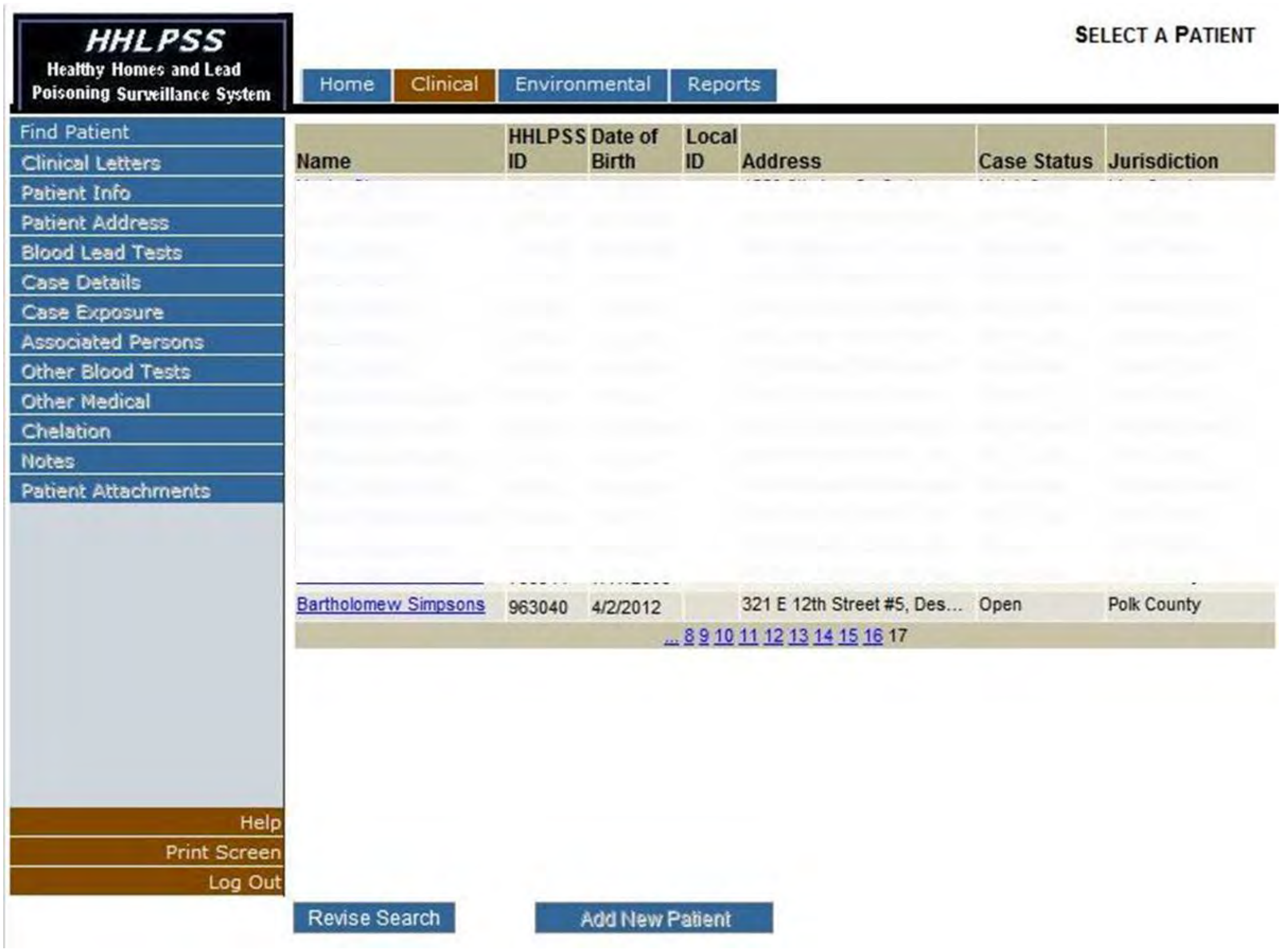
This will direct the browser to the “Find Patient” screen.



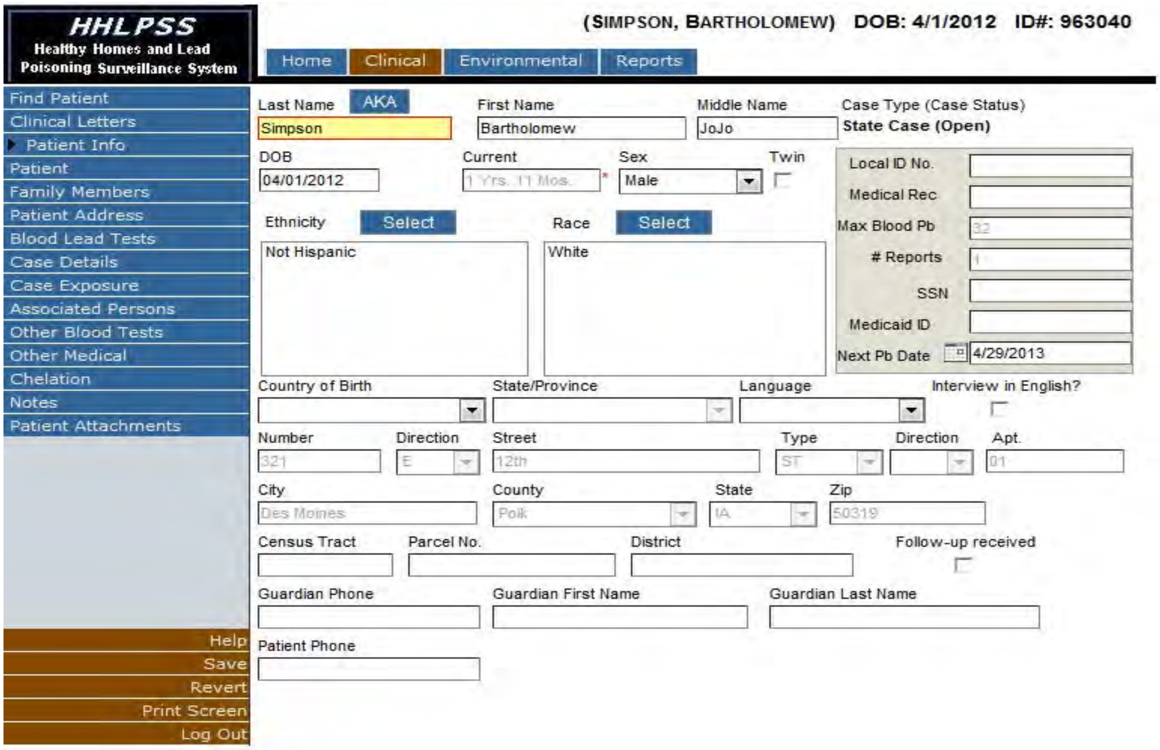
You will not be able to add a new patient to HHLPSS. However, you must search for a patient prior to receiving the option to edit the record.

To select a patient for viewing, click on the “Find Patient” link at the top of the left-hand menu. This will display a page that will allow you to enter search criteria for the patient record that you want to view. Enter the search criteria for the patient and then press “Search” button. A list of matching records will be displayed. Once you have selected a patient record (by clicking on the associated hyperlink) a summary screen will be displayed containing the patient's Name, HHLPSS ID, Date of Birth, Local ID, Address, Case Status, and Jurisdiction.

If you return more search results than you would like to browse through, click the “Revise Search” button near the bottom of the page and add additional search criteria.


HHLPSS
Healthy Homes and Lead Poisoning Surveillance System
Home
Clinical
Environmental
Reports
SELECT A PATIENT
Find Patient
Clinical Letters
Patient Info
Patient Address
Blood Lead Tests
Case Details
Case Exposure
Associated Persons
Other Blood Tests
Other Medical
Chelation
Notes
Patient Attachments
Help
Print Screen
Log Out
Name
HHLPSS ID
Date of Birth
Local ID
Address
Case Status
Jurisdiction
Bartholomew Simpsons
963040
4/2/2012
321 E 12th Street #5, Des...
Open
Polk County
... 8 9 10 11 12 13 14 15 16 17
Revise Search
Add New Patient

If the patient which you wish to edit is listed within the search results, click the patient name in the "Name" column to open the "Patient Information" screen.



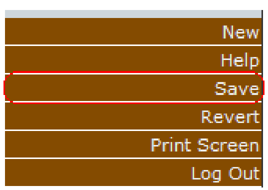
From the Patient Details screen, the user can view or edit the patient's demographic information. The screen also provides a view of the patient's current address, Guardian name and phone number.

Patient Details User Form Field Listing

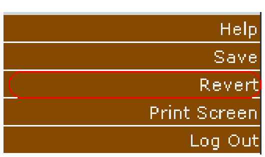
Field Name	Meaning
Last Name	Last name of patient
First Name	First name of patient
Middle Name	Middle name of patient
DOB	Date of birth of patient
Current Age	Current age of patient (system generated)
Sex	Gender of patient
Twin Indicator	Indicates whether the patient record was born apart of a multiple birth
Ethnicity	Patient's ethnicity
Race	Patient's Race
Local ID No.	Patient identifier utilized by local health department or entity
Medical Rec.	Medical record number of patient

Max Blood Pb	Patient's maximum blood test result value
# of Reports	Number of blood lead tests on file for patient.
SSN	Social Security Number of Patient
Medicaid ID	State Medicaid identifier for patient
Next Pb Date	Date the next blood test is due for patient
Country of Birth	Country of birth for patient
State/Province of Birth	State or province of birth for patient
Language	Patient's primary spoken language.
Interview in English? Indicator	Indicates whether case management interview was conducted in English
Patient Address details (view only)	View of current address of patient
Patient Phone and Guardian Information (view only)	View of the primary guardian contact info for patient.

If you edit any patient details, click the "Save" button in the (burgundy) bottom left corner menu to save the changes. (If you navigate away from the page without saving, your changes will be lost).



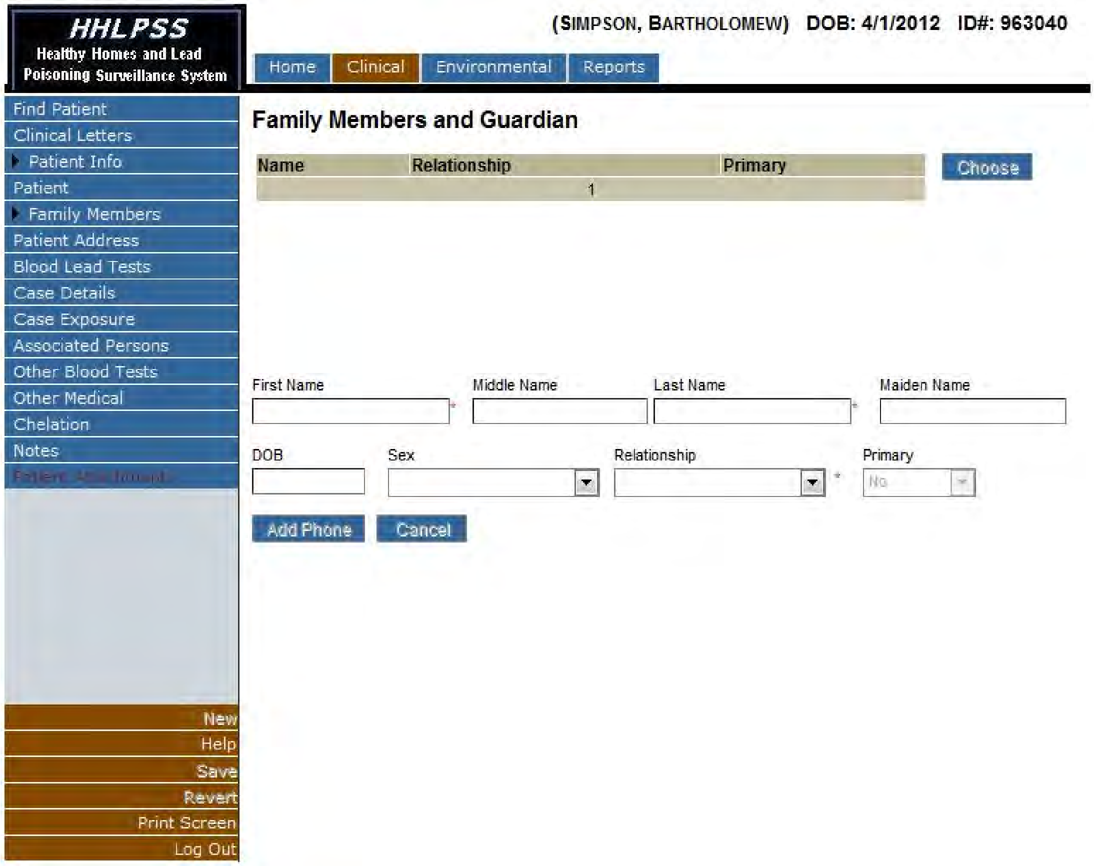
If you wish to cancel your changes prior to saving, click the "Revert" button in the (burgundy) bottom left corner menu to revert to the prior values.

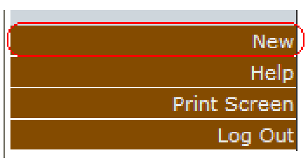


Family Members and Guardian Screen

The Family Members and Guardian Screen will be utilized to input details of the family members related to the selected patient and phone numbers corresponding to each guardian.

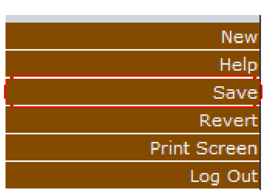
To add a new family member or guardian for the selected patient, click the "New" button in the (burgundy) bottom left corner menu to enable the fields to add a new family member.





The minimum fields required to create a family member are indicated with a red asterisk [*] and are First Name, Last Name and the Relationship to Child.

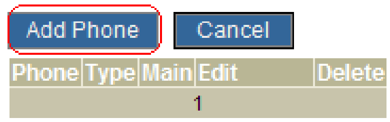
Input the corresponding data in these and the other fields corresponding to the new family member and click the “Save” button in the (burgundy) bottom left corner menu to save your new provider.



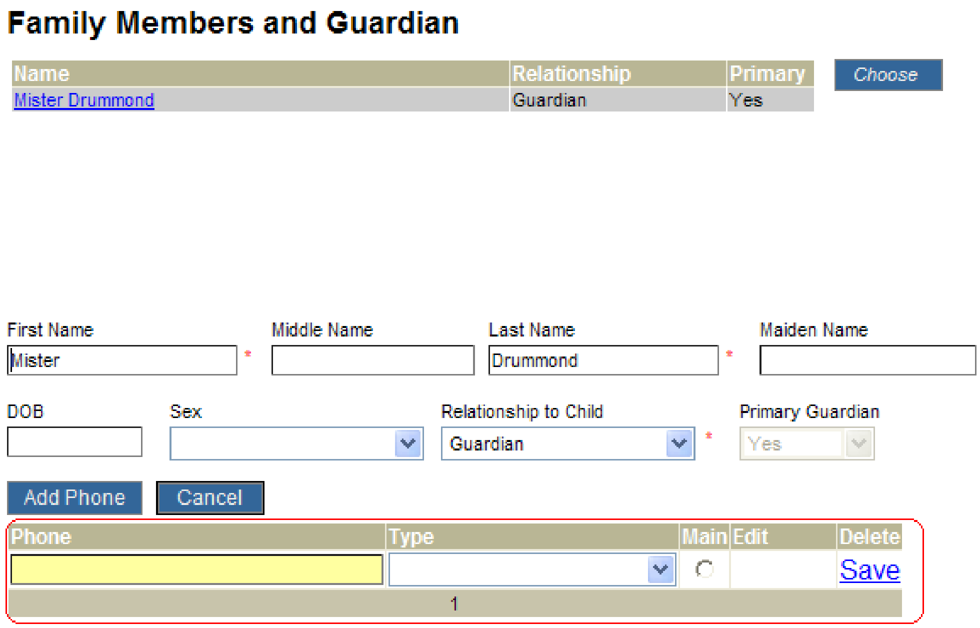
After the record is saved, the family member will be added to the family member list and will be active in the user form for the addition of additional details and a contact number.

To edit any other family member’s information, click the name of the family member link in the list.

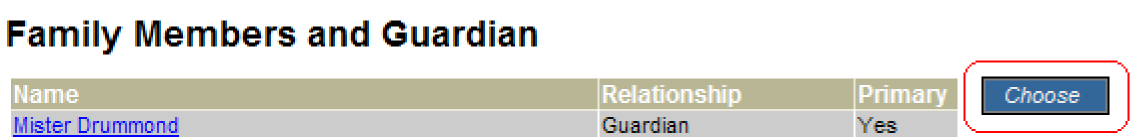
To add a contact number for the family member, with the family member selected in the "Family Members and Guardian" listing; click the "Add Phone" button.



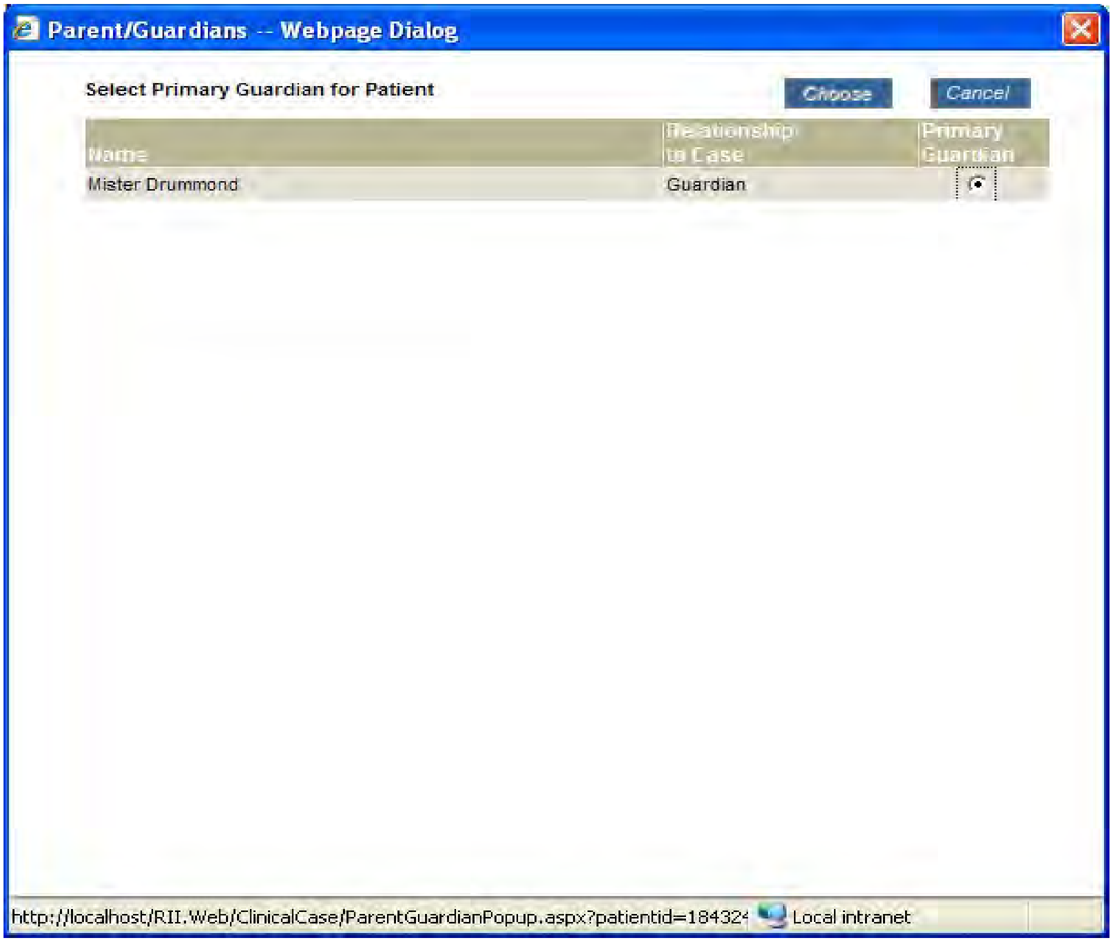
This will open the add phone number control within the page.



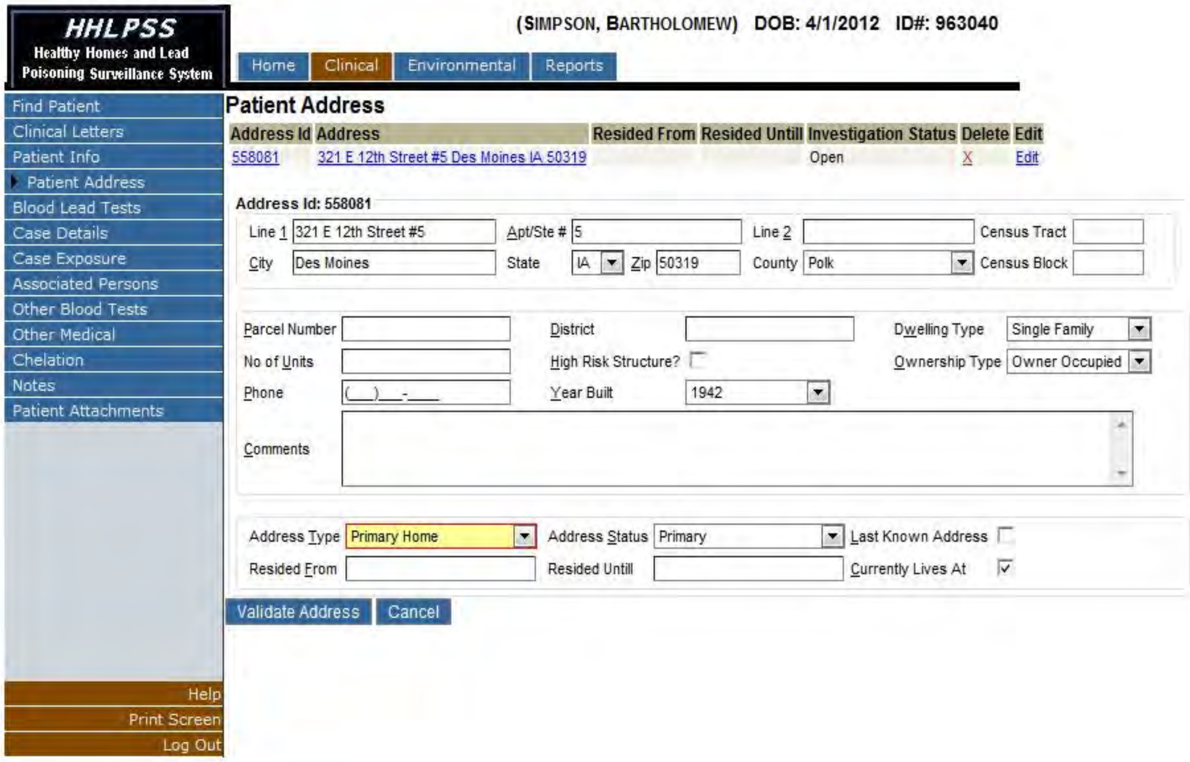
Input a ten digit phone number format of (XXX) XXX-XXXX and select a phone type. Click the radio button labeled in the main column, if the phone number is the main contact number for the patient. Click "Save" to add the phone number to the family member record. You can add additional phone numbers by clicking the "Add Phone" button.



Clicking the “Choose” button allows the user to designate a “primary guardian” from the family members listing for the patient.



Patient Address History Screen



The Patient Address History Screen will be utilized to view and input details related to the selected patient's current and former addresses.

Patient Address User Form Field Listing

Field Name	Meaning
Line 1	Street Address
Line 2	Street Address Line 2
Apt/Ste #	Apartment or Suite Number
City	City
State	State
Zip	Zip Code
County	County
Census Tract	Address census tract
Parcel Number	Local parcel number of address
District	Address district
Dwelling Type	Selected dwelling type (Single, multi family, etc.)
Number of Units	If multi-unit dwelling, number of units within

	dwelling
High Risk Structure	Was the dwelling built prior to 1978
Address Description	Free text description of address record
Address Type	Type of address (i.e. primary home, vacation home, etc.)
Address Status	Statuses of patient address (primary, former, etc.)
Reside or spent time dates	Dates patient resided at address (“Until” is blank if patient currently resides at address)
Last known address indicator	Indicates whether this is the last known address on file for the patient.
Currently resides at indicator	Indicates whether the patient currently resides at address
Ownership Type	Ownership type of residence (Owner occupied, rental, etc.).
Phone	Phone number associated with address

The current address will be selected in the address list and active within the user form below the address list.

Clicking the “Address ID” link in the Address Listing will select the address within the Clinical Module form below the listing. Clicking the “Address” link will direct the browser to the Environmental Module to view more address details.

The user can edit the address details within the Clinical Module click the “Edit” link. If the selected State is change the page may reload to populate the county list control.

To begin saving changes to the address record, click the “Validate Address” button beneath address details form. Address validation attempts the correction of any missing or incorrect address details and the addition of geocoding data (census block, census tract, latitude and longitude).

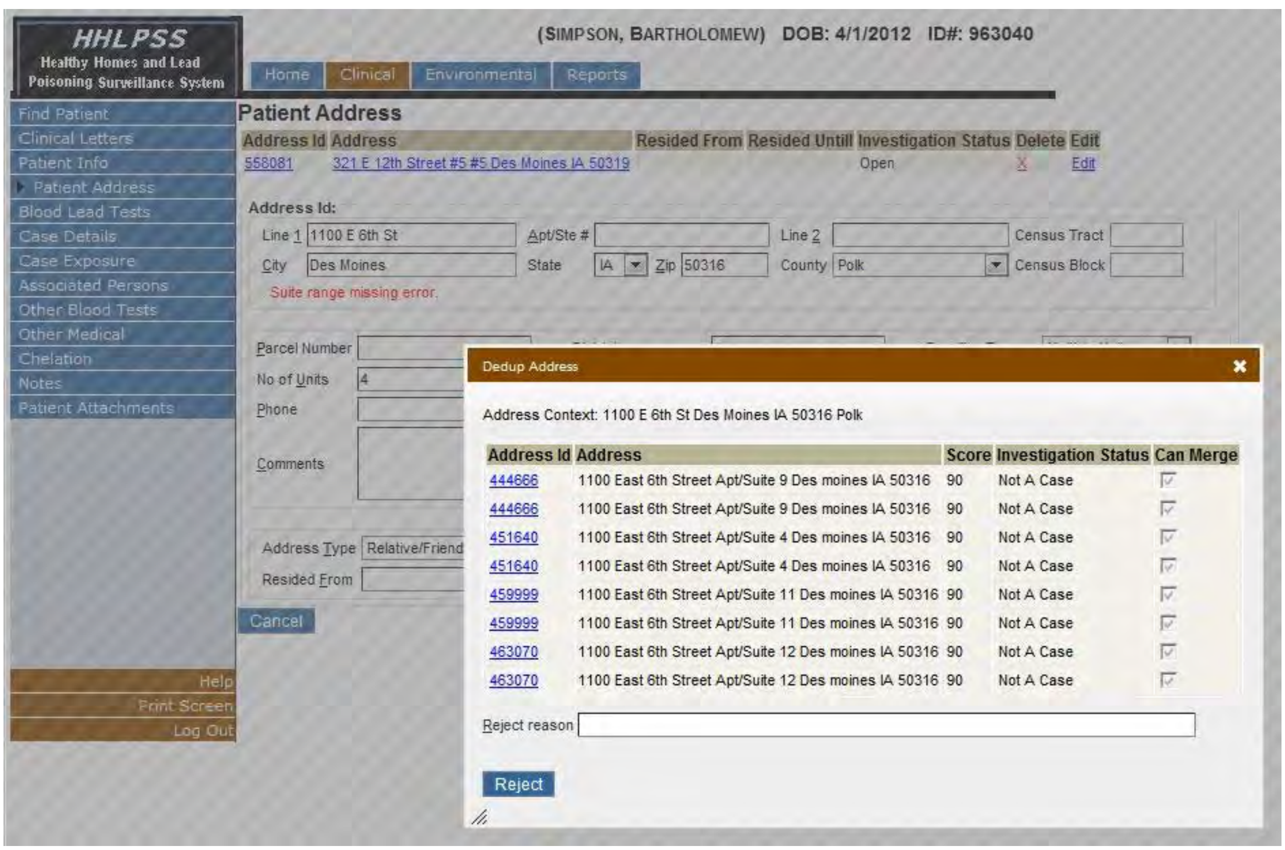
Once the address validation has been attempted, click the “Save Address” button will be presented to finalize the address save operation.

To add a new address to the patient’s address history, click the “Add Patient Address” button beneath address details form to enable the fields to add a new address for the patient.

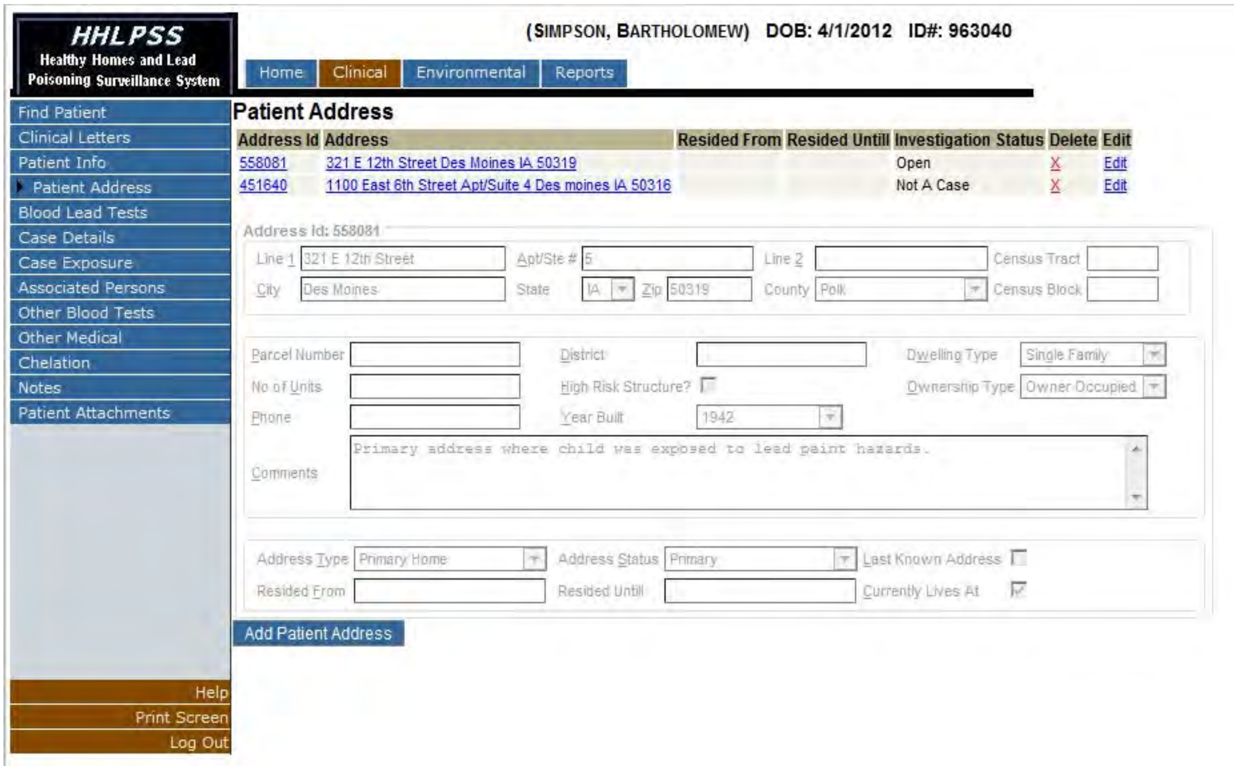
Input the address details in the appropriate address field.

De-duplicate Address Popup

The de-duplicate address popup allows for selection or rejection of possibly matched address records. To select an existing record as a match to the newly entered record, select the address id corresponding to the matched address. If you wish to reject all possible matches and create a new address record, enter a rejection reason in the ‘Reject reason’ field and click the ‘Reject’ button.



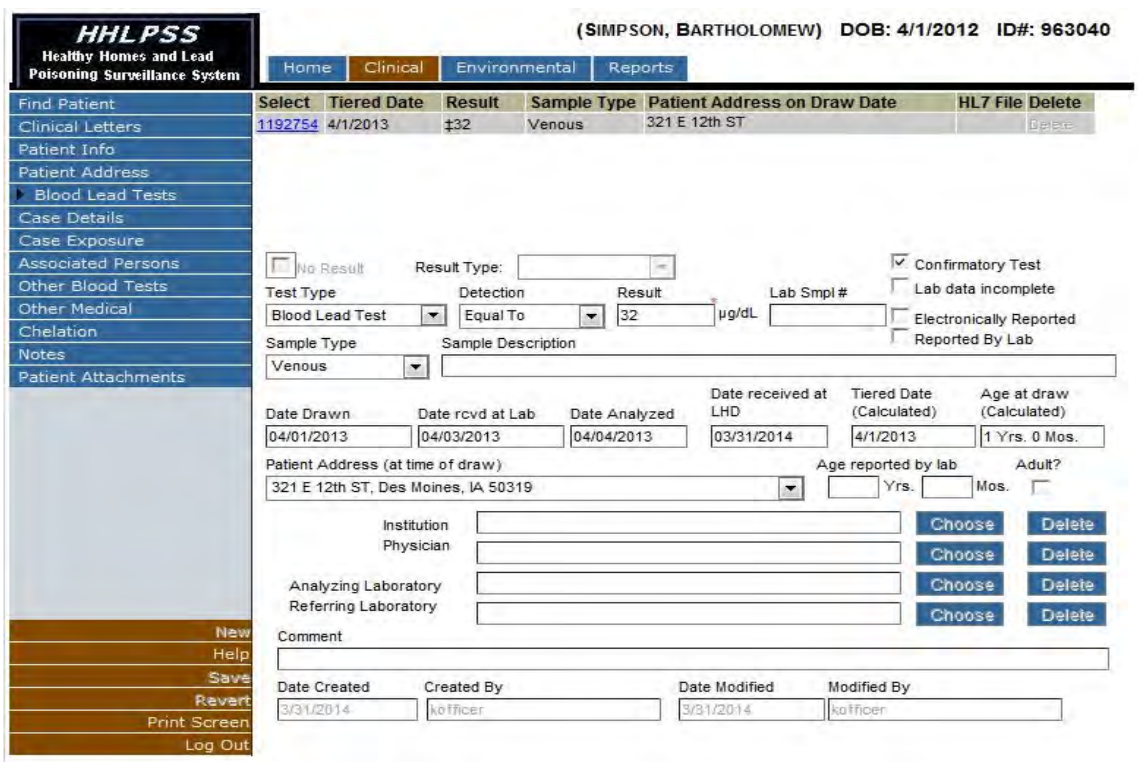
De-Duplicate Address



Blood Lead Testing History

The Patient Blood Test History Screen will be utilized to view and input details related to the selected patient's blood lead testing history.

The earliest test available will be selected in the blood test list and active within the user form below the blood test list.



The user can select any blood lead test within the listing of tests for the patient by clicking the test identifier number link in the “Select” column of the blood test list.

The user will not be able to edit or add additional blood lead information. If the patient’s blood lead test data needs to be updated contact IDPH (1-800-972-2026) with the correct patient information.

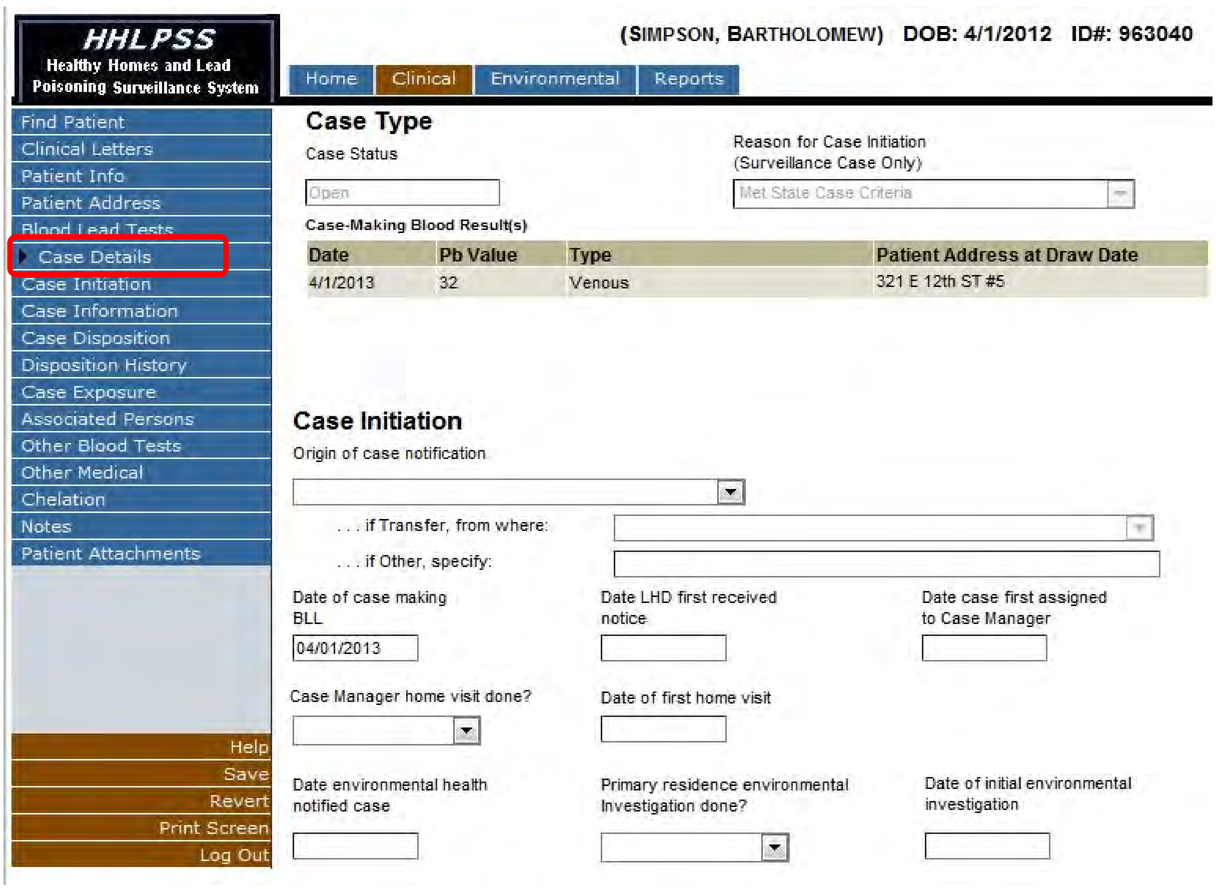
Blood Lead Test User Form Field Listing

Field Name	Meaning
Test Type	Type of laboratory test (i.e. blood lead test)
Result	Result value of test
Lab Sample Number	Sample number assigned by laboratory
Detection	Results value comparator (=, >, <)
Confirmatory Test	Indicates whether the blood tests is a confirmatory test
Lab data incomplete	Indicates whether the blood lead test is missing data
Electronically Reported by Lab	Indicates whether the record was electronically reported
Sample Type	Sample the type reported by lab (i.e. venous, capillary, or unknown)
Sample Description	Free text a description of blood tests in the
Date Drawn	Date sample was drawn from patient
Date received at lab	Date laboratory received sample from provider
Date received at the local health departments (LHD)	Date blood lead test record was received by State or Local health department
Tiered Date (System Calculated)	Date utilized to calculate date ranges base upon dates associated with address (set to Date Drawn if available)
Age at draw (System Calculated)	Age of patient at date drawn
Patient address	Choose the address of the patient associated with blood test.
Adult indicator	Indicates whether the patient should be considered an adult
Institution	Institution where sample was provided (hospital or clinic)
Physician	Provider who drew or recommended blood lead test

Analyzing laboratory	The laboratory which analyzed the sample..
Referring laboratory	The laboratory which referred the sample to analyzing lab.(if necessary)
Comment	Free text comments
Date created	The date blood test record was created (system generated)
Created by	User who created blood test record (system generated)
Date modified	Date blood test record was modified (system generated)
Modified by	User who modified blood test record (system generated).

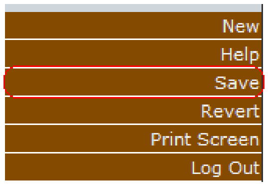
Case Details/ Case Initiation

Details related to the current patient's case history can be view by selecting the "Case Details" menu item.



This will activate the "Case Initiation" screen. This screen captures details related to the creation of the patient case.

Input the details related to the initiation of the case into the specified fields. To save, click the “Save” button in the (burgundy) bottom left corner menu to update the case initiation data.



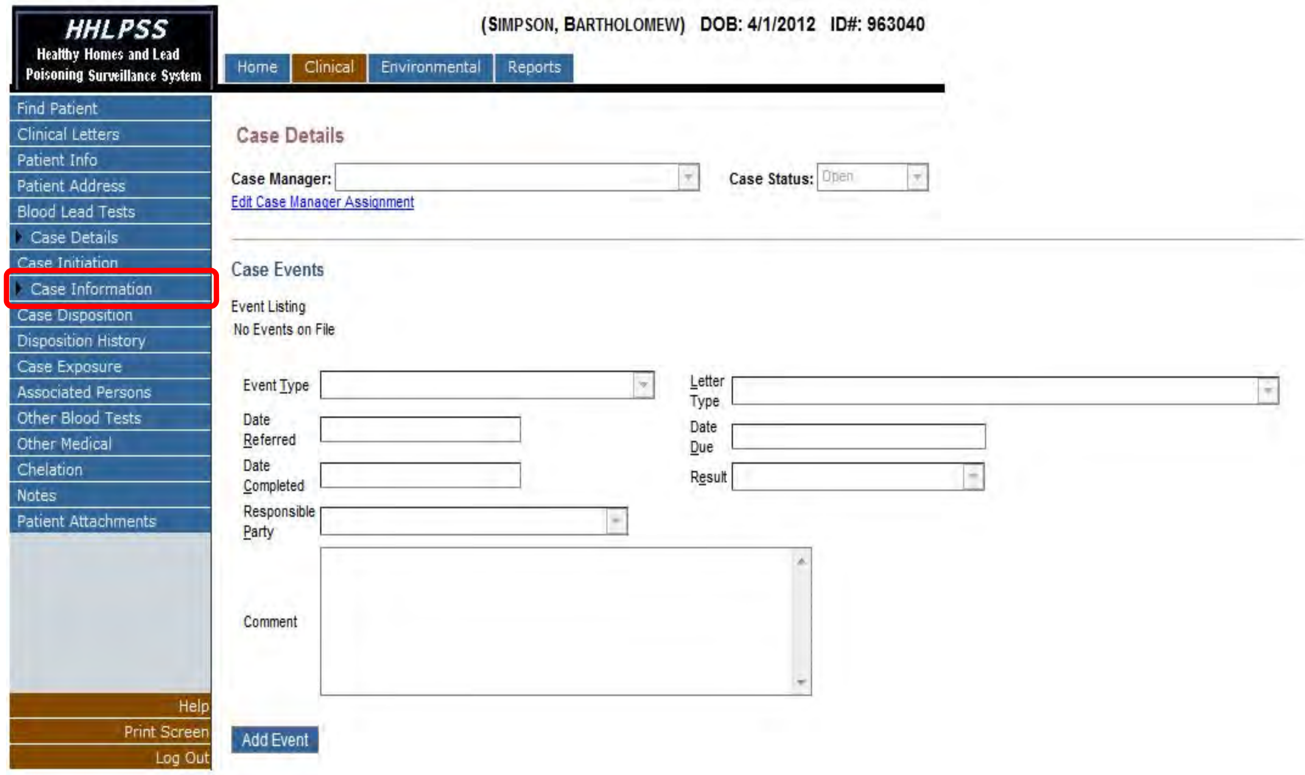
Case Initiation Form Field Listing

Field Name	Meaning
Case Status	Type of laboratory test (i.e. blood lead test)
Reason for Case Initiation	Result value of test
Case Making Blood Results Listing	Sample number assigned by laboratory
Origin of case notification	Select the first source of case notification to the local Health Department from the choices given: **Lab** - The laboratory that determined the patient’s blood lead level. **State** - The state health department’s Childhood Lead Poisoning Prevention Branch. **Provider -** The child’s medical provider. **Transfer From Other Health Department** - Choose this option if the case has been transferred from another health department. If this option has been selected, the **. . . if Transfer, from where** drop-down immediately below will be activated and you will need to specify the health department. **Other** - If none of the above options are correct, use this option. When **Other** is selected, the **. . . if Other, specify** field below is activated. This is a free-form text field that allows you to type a short description of the origin of the case.
If transfer, from where	This drop-down menu is active only if the **Origin of case notification** drop-down is set to **Transfer From Other Health Department**. Use it to specify the jurisdiction that the case has transferred from.
If other, specify	This text-entry field is only enabled when the **Origin of case notification** drop-down is set to **Other**. Use this field to specify the other source of the case notification
Date of Case making BLL	Specify the date the case-making Blood Lead Level (BLL) draw occurred.

Date LHD first received notice	Specify the date that the local health department (LHD) was first notified of the case. This date specified here should be the date that the LHD first learned of the case, regardless of the source of that notice.
Date case first assigned to PHN	Specify the first date that the case was assigned to a PHN.
PHN Home visit done	Select **Yes**, **No**, or **Unknown** to indicate whether a site investigation has been done for this case.
Date of first home visit	This field is active only if the **PHN home visit done?** drop-down is set to **Yes**. If a home visit has been made, use this field to specify the date of the first visit. This should be the date the home was first visited and not necessarily the date of the first family interview.
Date environmental health	Specify the date of the first notification.
Primary residence environmental investigation done.	Select **Yes**, **No**, or **Unknown** to indicate whether an environmental investigation has been done for this case. Select **Yes** if the environmental investigation of the primary residence has been completed. Other investigations (daycare, grandparents, etc.) need not have been completed yet.
Date of initial investigation	This field is active only if the **Primary residence environmental Investigation done?** drop-down is set to **Yes.** If an environmental investigation has occurred, use this field to specify the date that the investigation took place.

Case Details/Information

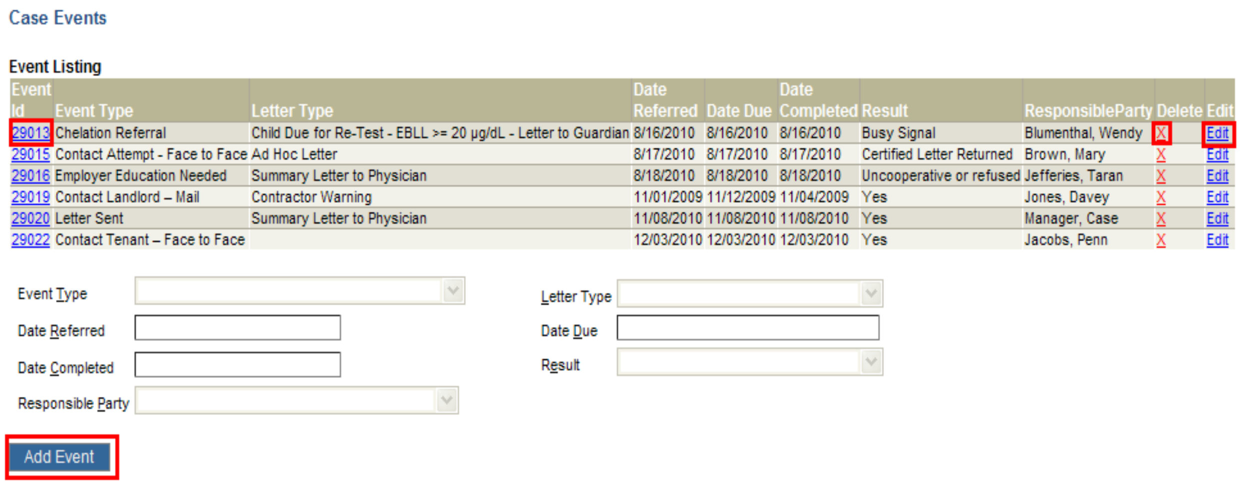
The "Case Details" page allows the user to view and edit selected case information and events associated with a selected patient.



Case manager assignments can be viewed or changed in the upper portion of the screen. The current case status is also display however, it is not editable.

To change the case manager assignment for the patient's case, click the "Edit Case Manager Assignment" hyperlink. Select the appropriate case manager from the list of available case managers and then click the "Assign Case Manager" hyperlink.

Case events are utilized to record regularly recurring case actions in a tabular listing. Past Case events can be viewed, edited, or deleted from the 'Event Listing' table in the lower portion of the screen.



Case Events

Event Listing

Event Id	Event Type	Letter Type	Date Referred	Date Due	Date Completed	Result	ResponsibleParty	Delete	Edit
29013	Chelation Referral	Child Due for Re-Test - EBLL >= 20 µg/dL - Letter to Guardian	8/16/2010	8/16/2010	8/16/2010	Busy Signal	Blumenthal, Wendy	X	Edit
29015	Contact Attempt - Face to Face	Ad Hoc Letter	8/17/2010	8/17/2010	8/17/2010	Certified Letter Returned	Brown, Mary	X	Edit
29016	Employer Education Needed	Summary Letter to Physician	8/18/2010	8/18/2010	8/18/2010	Uncooperative or refused	Jefferies, Taran	X	Edit
29019	Contact Landlord – Mail	Contractor Warning	11/01/2009	11/12/2009	11/04/2009	Yes	Jones, Davey	X	Edit
29020	Letter Sent	Summary Letter to Physician	11/08/2010	11/08/2010	11/08/2010	Yes	Manager, Case	X	Edit
29022	Contact Tenant – Face to Face		12/03/2010	12/03/2010	12/03/2010	Yes	Jacobs, Penn	X	Edit

Event Type

Letter Type

Date Referred

Date Due

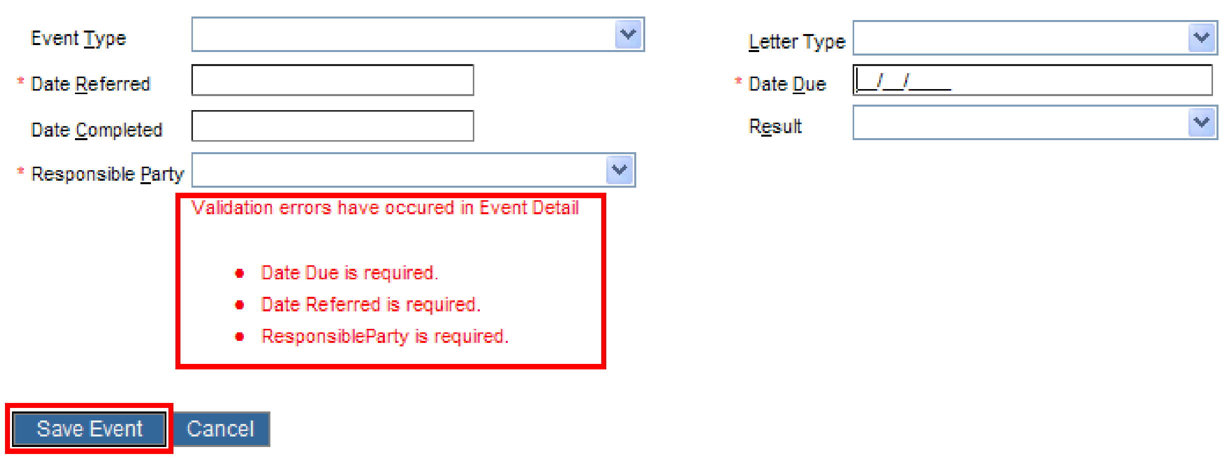
Date Completed

Result

Responsible Party

Add Event

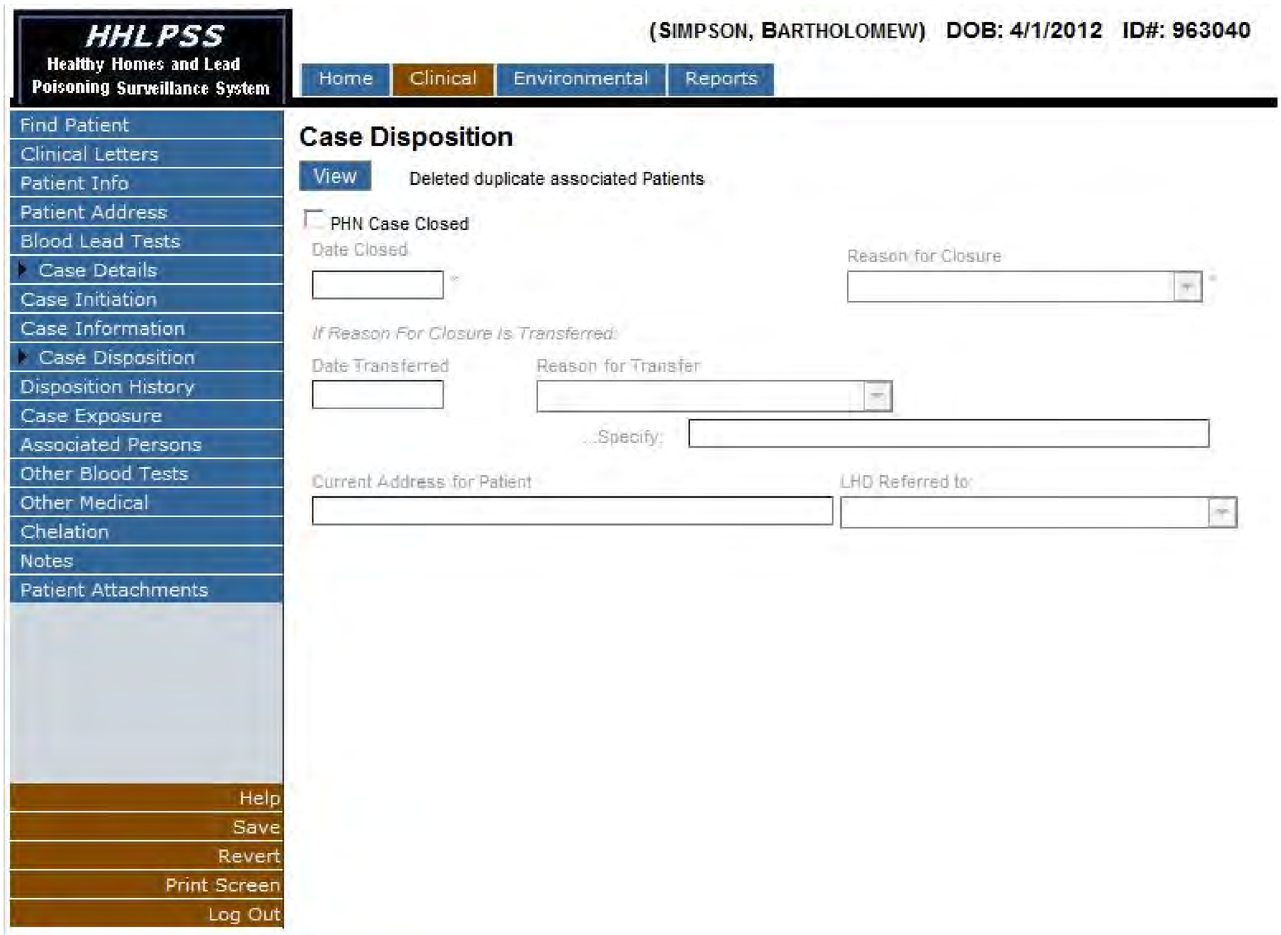
- To review the details of a past event, click the hyperlink corresponding to the 'Event Id' of the event of interest. The details of the event record will populate the user form below the 'Event Listing' table. The details will be made visible but not editable.
- To edit past event details, click the 'Edit' hyperlink in the row corresponding to the event of interest. The details of the event record will populate the user form below the 'Event Listing' table and the form will be activated for editing.
- To delete a past event, click the red 'X' [X] in the 'Delete' column of the row corresponding to the event of interest.
- To add a new event, click the 'Add Event' button below the event form. The form will be activated for data entry. Input the required Event data items (Event Type, Date Referred, Due Date, and Responsible Party). Click the 'Save Event' button to commit the event record to the system data store.
- If validation errors are found, they will be display below the form and above the 'Save Event' and 'Cancel' buttons.



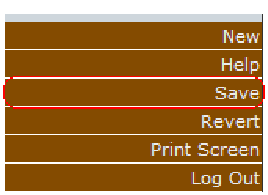
Case Disposition – Case Closing

To close a case or view details related to a cases closure, select “Case Disposition” from the “Case Details” sub menu under the Clinical Tab of HHLPSS.

The “Case Disposition” screen captures details related to the closure of the patient case.



Input the details related to the closing of case into the specified fields. To save, click the “Save” button in the (burgundy) bottom left corner menu to update the case disposition data.



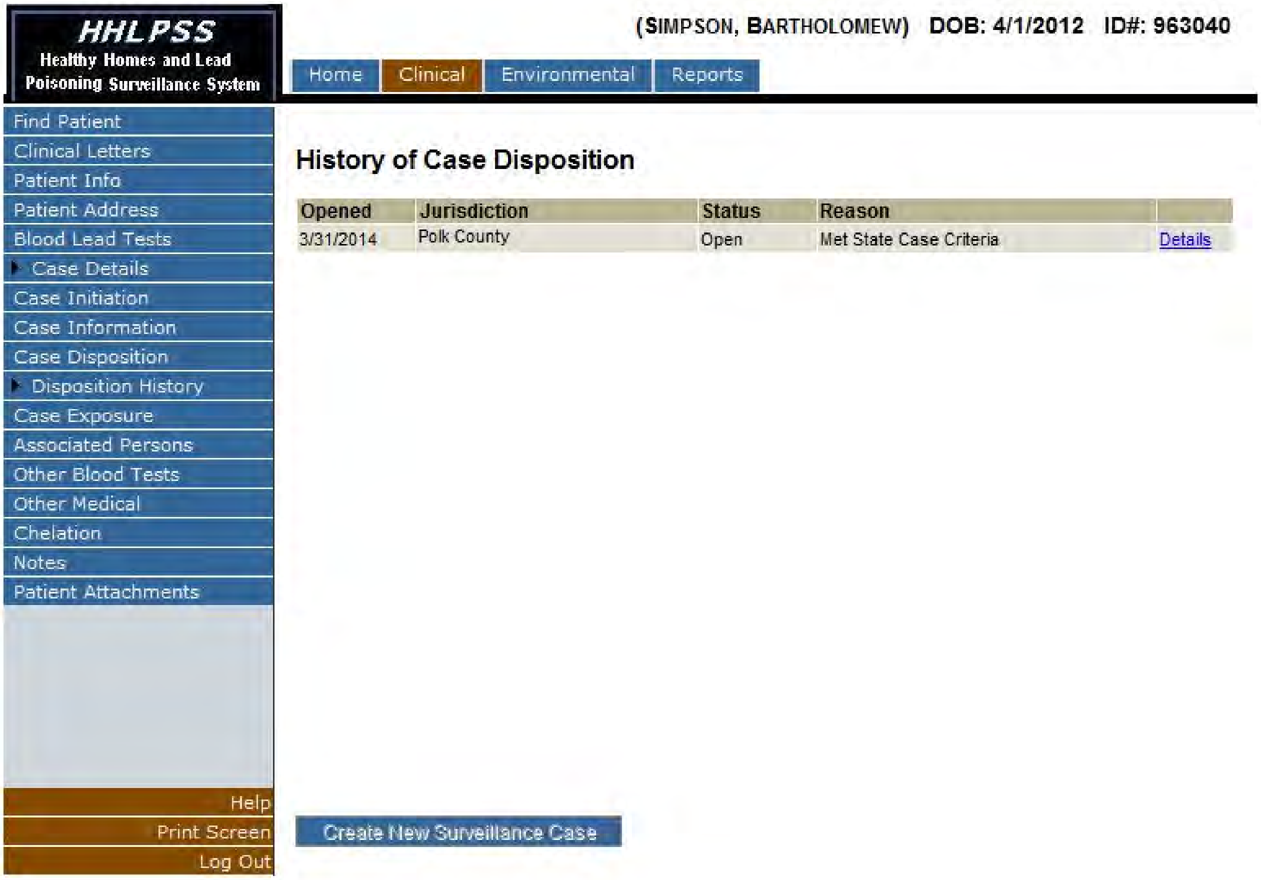
Case Disposition Form Field Listing

Field Name	Meaning
Deleted duplicate associated patients	View patients merged with current record through record de-duplication processing.
PHN Case Closed	Select to indicate case closure
Date Closed	Indicate the date that the case was considered closed by the state or local health department.
Reason for closure	• If the case has been closed because it's invalid (not because it's a valid case that's eligible for closure) select the top- level **Not a Case** button and then take the following steps: • Choose the reason that the case is being closed (**False Positive**, **EBL, not State case** or **Clerical Error**). **EBL, not State case** should be used when you have opened a case file on a child not meeting the state CLPPB case criteria. • If you select **False Positive** as the reason for closure, the list box to the right of the check box will become enabled and you should use it to select the original, case-making BLL and the subsequent result that invalidated it. • If you select **Clerical Error** as the reason for closure, the list box to the right of the check box will become enabled and you should use it

Field Name	Meaning
	to select the original, case-making BLL that was entered in error. • If a valid case was closed, select the top- level **PHN Case Closed** check box and then take the following steps: • Use the **Reason for Closure** drop-down to indicate the reason that the case was closed: • **Standard Clinical Case Closure** - Select this option if the case was closed because it met clinical case closure criteria. • **Persistent Refusal** - Select this option if the case was closed because the patient has persistently refused to be re- tested after an initial case-making result. If you are closing the case for this reason, use the **Notes** section of the **Clinical** tab (at the very bottom of the menu bar on the left side of the page) to document the basis in the case file. • **Unable To Locate Family** - Select this option if the case was closed because the patient's family cannot be located. If you are closing the case for this reason, use the **Notes** section of the **Clinical** tab (at the very bottom of the menu bar on the left side of the page) to document the basis in the case file. • **Transferred To Other Health Dept** - Select this option if the patient has moved to another Jurisdiction (You will need to specify where the patient has transferred to, see Step 3 below.) • **Admin** - Select this option if the case was closed for other, administrative reasons (e.g., patient has reached the age of 21). • **State Case Opened** - Select this option if a surveillance case is being closed in favor of a State case. • If the reason for closure was **Transferred To Other Health Dept**, the following fields become enabled and should be filled out before
Date Transferred	If case is being transferred to another jurisdiction, enter the date of transfer.
Reason for transfer	Reason for Transfer - Use this drop- down to provide information about the nature of the transfer:
Specify	Specify reason for jurisdiction transfer not within list.
Current Address	Use this field to enter the current address for the patient (i.e., the address the patient has transferred to).
LHD referred to	Use this drop-down to select the local health department that the patient has transferred to.

Disposition history – case history

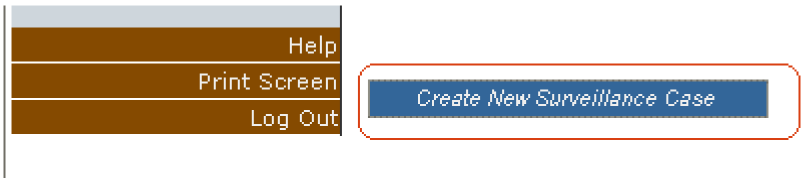
To view the history of the patient's past case status, select "Disposition History" from the "Case Details" sub menu under the Clinical Tab of HHLPSS.



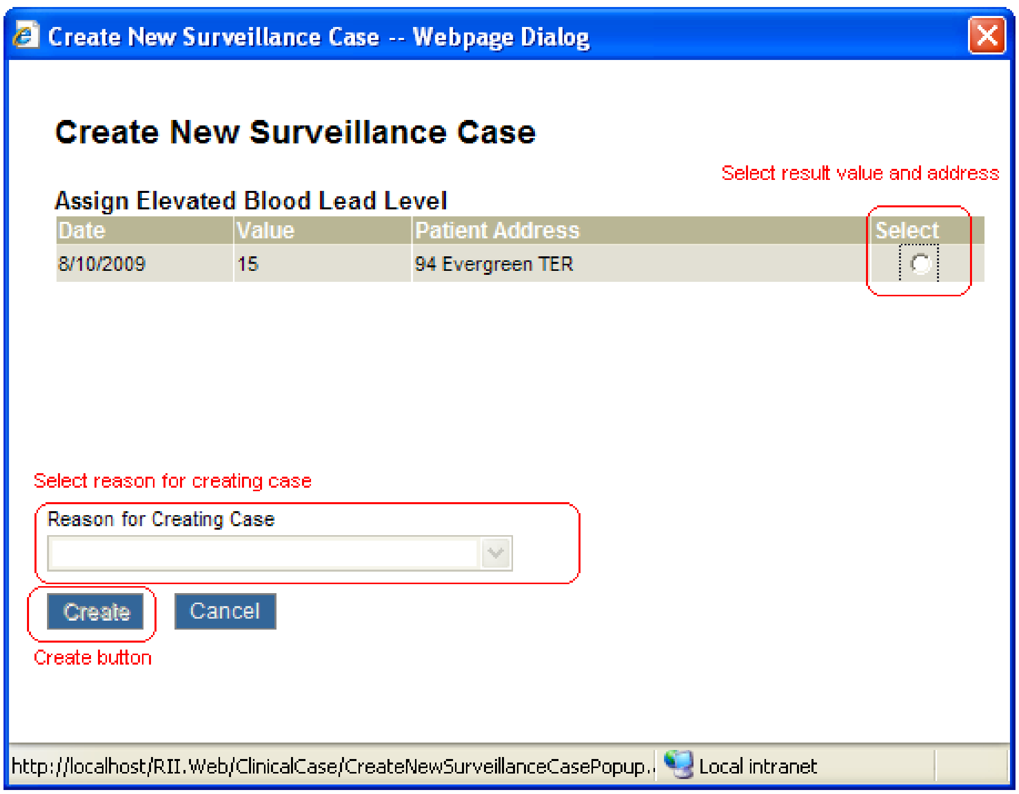
The "Disposition History" screen displays details related to the history of the current patient's case status. The details of patient's current and past cases can be viewed within this screen. To edit or view closure details of a past case, click the "Details" link in the patient's case listing. This will activate the "Case Disposition" screen for the selected case.

Manually Open Patient Case

To manually open a case for a patient, click the "Create New Surveillance Case" button near the bottom of the "Disposition History" page. The patient must current have no case or a previously closed case.



This will activate the "Create New Surveillance Case" popup. This popup allows for the manual creation of a patient case.



Select a blood lead result value and address to associate with case, by clicking the radio button in the "Select" column.

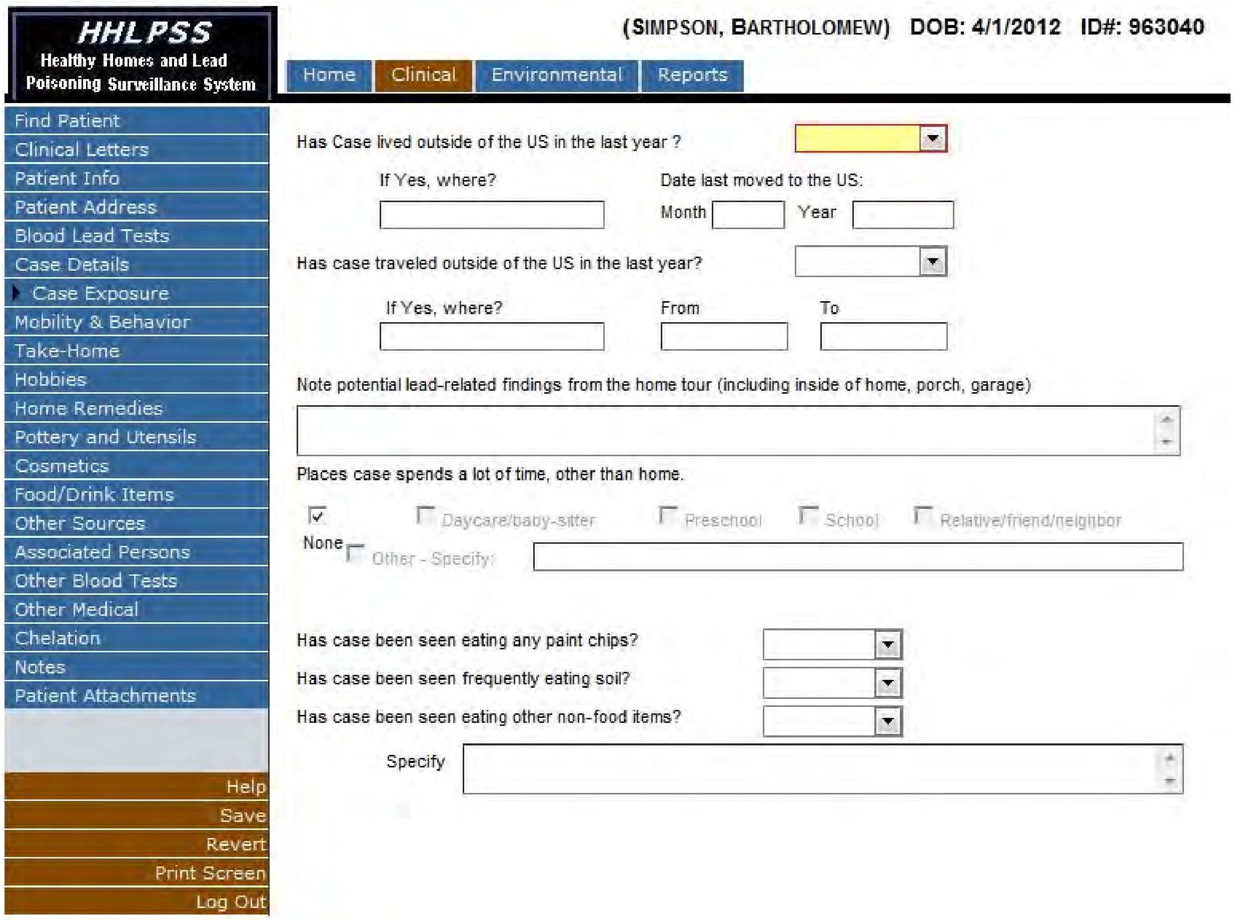
Select a reason for manual case creation from the list of available choices.

Click the "Create" button.

Close out "Create New Surveillance Case" popup

Case Exposure Sources

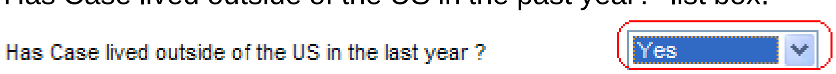
To input details relating to a patient's possible exposure to lead sources utilize the "Case Exposure" menu item of the "Clinical" tab



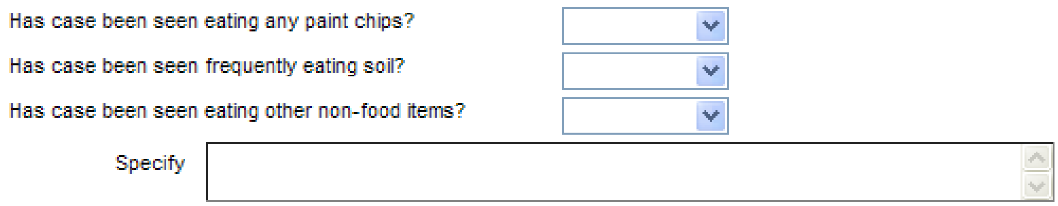
The "Case Exposure" menu item expands a sub menu of pages designed to collect data related to possible exposure sources for the patient case. *These pages cannot be edited if the patient does not have a case that is currently open.*

Mobility & Behavior

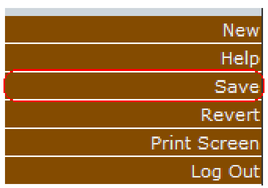
The "Mobility & Behavior" page allows the user to input details related to the patient's movement outside of the United States and specific behaviors considered to increase the likelihood of lead exposure. To activate the fields related to mobility, select "Yes" from the list of choices in the "Has Case lived outside of the US in the past year?" list box.



To input details related to at risk behavior fill the details related to at risk behavior near the bottom of the page.

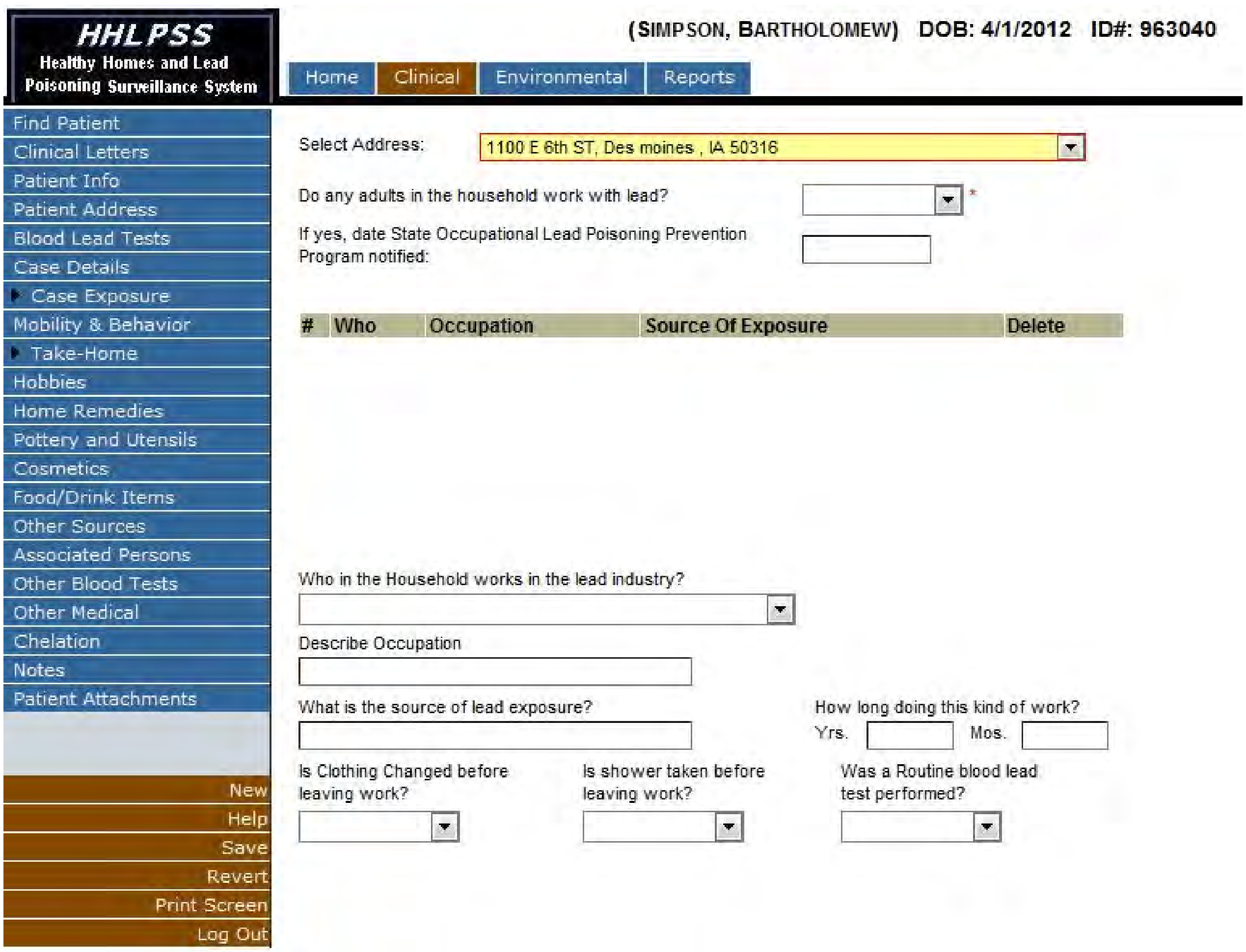


To save, click the “Save” button in the (burgundy) bottom left corner menu to update the patient exposure data.

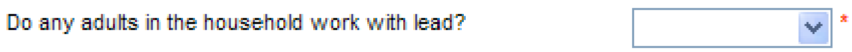


Take Home [Exposure Sources]

To input details relating to a patient’s possible take home exposures to lead sources utilize the “Take-Home” menu item of the “Clinical” tab



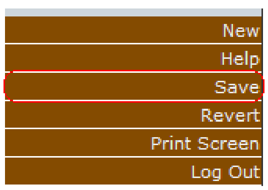
The “Take Home” exposure page allows the user to input details related to the patient’s families’ possible occupation exposures to lead. To activate the fields related to take home exposures select “Yes” from the list of choices in the “Do any adults in the household work with lead?” list box.



Input data related to the family members occupation in user form near bottom of page.

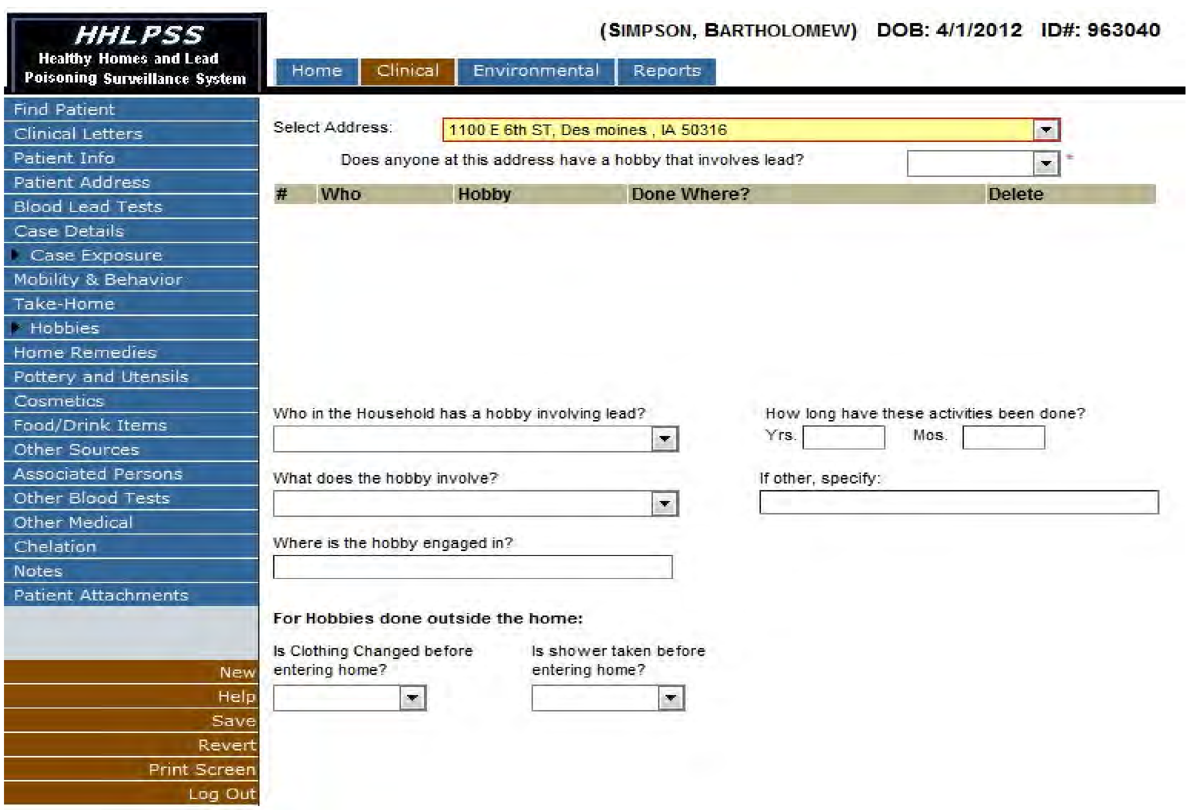
The minimum fields required to create a take home exposure record are display with a red asterisk [*] and are Date state occupational lead program notified, Who in the Household works in the lead industry, and Describe Occupation.

Input the corresponding data in the required and other fields corresponding to the new take home exposure source and click the “Save” button in the (burgundy) bottom left corner menu to save record.

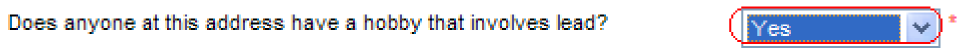


Hobbies

To input details’ relating to a patient’s possible exposures to lead sources during their hobby activities utilize the “Hobbies” menu item of the “Clinical” tab.



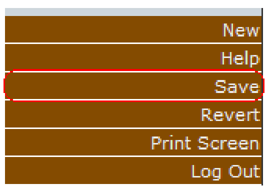
The “Hobbies” exposure page allows the user to input details related to the patient’s and the patient’s families’ possible occupation exposures to lead during hobby activities. To activate the fields related to take home exposures select “Yes” from the list of choices in the “Does any at the address have a hobby that involves lead?” list box.



Input data related to the patient’s and family members hobbies in user form near bottom of page.

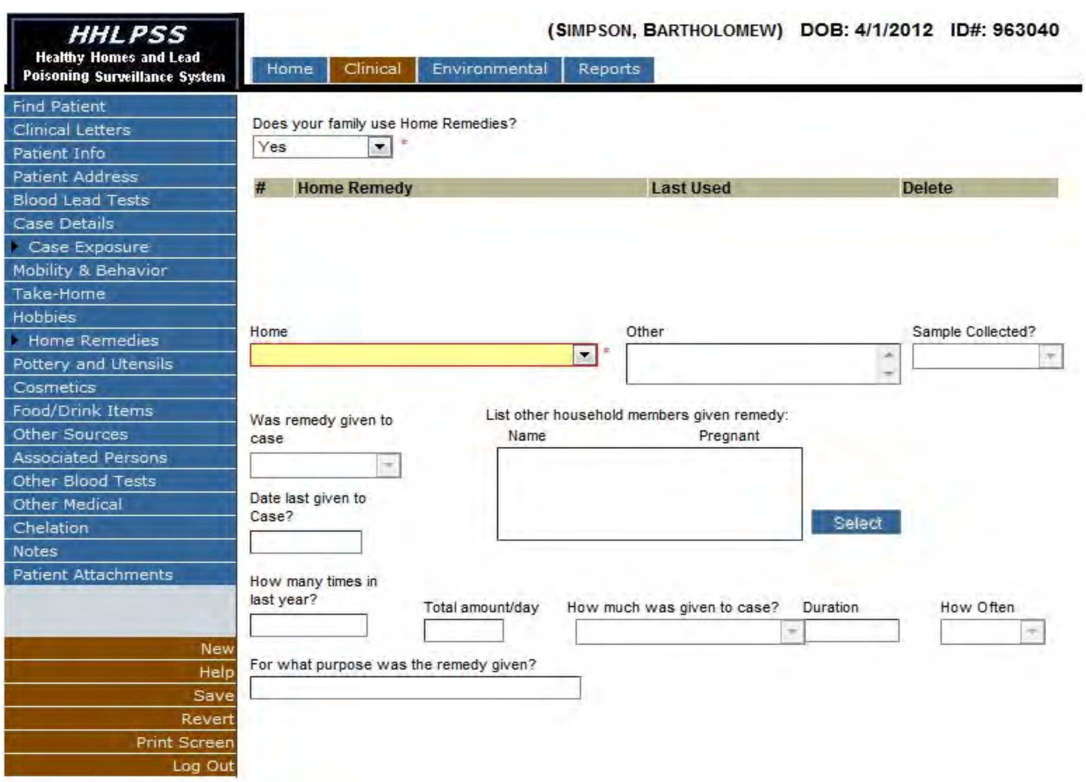
The minimum fields required to create a take home exposure record are display with a red asterisk [*] and are “Who in the household has a hobby involving lead?”, “What does the hobby involve?”.

Input the corresponding data in the required and other fields corresponding to the new hobby and click the “Save” button in the (burgundy) bottom left corner menu to save record.

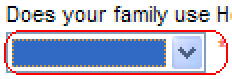


Home Remedies

To input details relating to a patient’s possible exposures to lead sources during the use of home remedies utilize the “Home Remedies” menu item of the “Clinical” tab



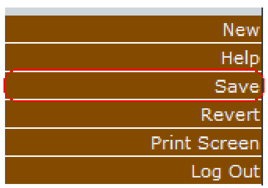
The “Home Remedies” exposure page allows the user to input details related to the home remedies utilized by the patient’s family and their possible relation to lead exposure. To activate the fields related to take home exposures select “Yes” from the list of choices in the “Does your family use Home Remedies?” list box.



Input data related to the family’s use of home remedies in user form near bottom of page.

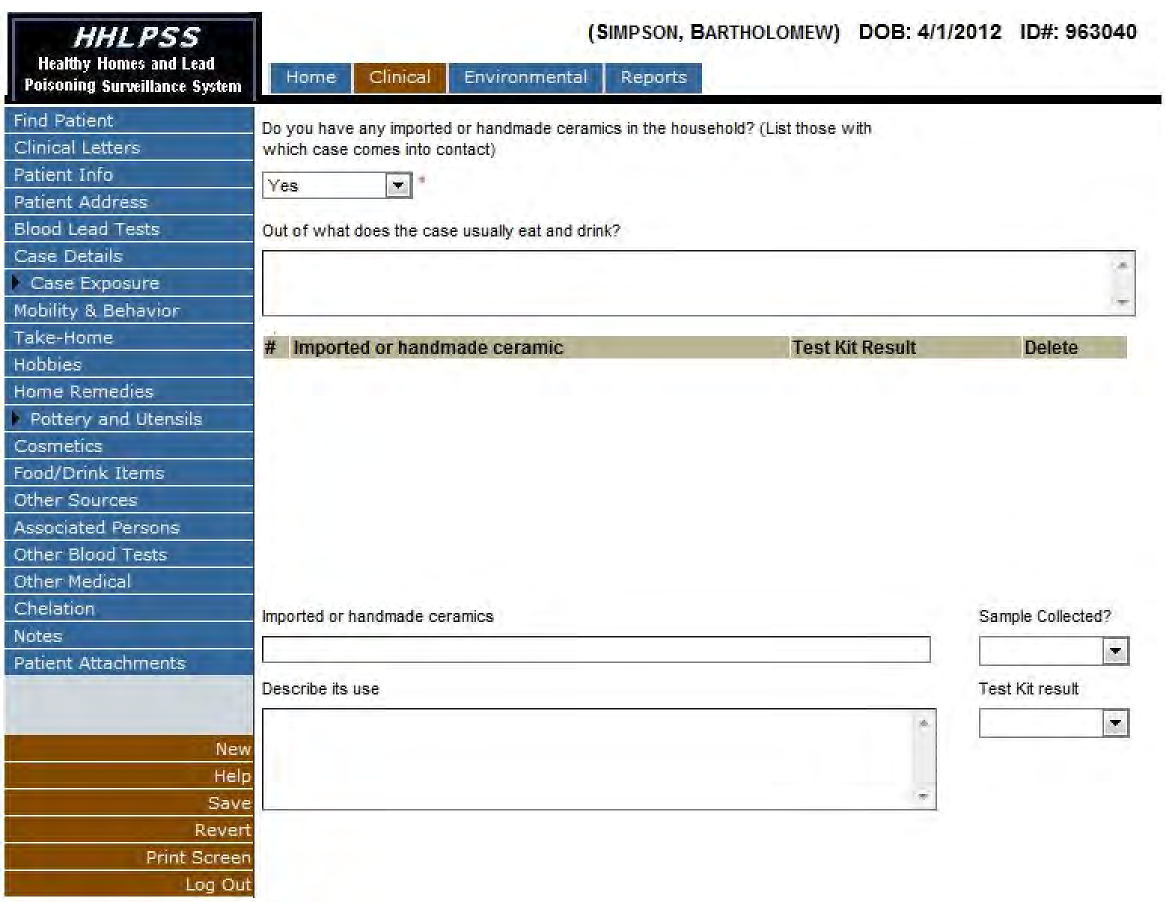
The only field required to create a take home exposure record is displayed with a red asterisk [ ] and is Home Remedy.

Input the corresponding data in the required and other fields corresponding for the new home remedy and click the “Save” button in the (burgundy) bottom left corner menu to save record.

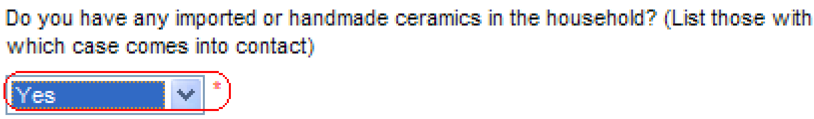


Pottery and Utensils

To input details relating to the patient’s exposures to lead sources during the use of household pottery or utensils, utilize the “Pottery and Utensils” menu item of the “Clinical” tab.



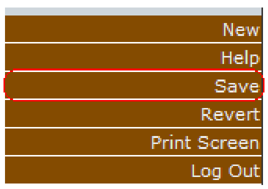
The “Pottery and Utensils” exposure page allows the user to input details related to the pottery and utensils utilized by the patient’s family and their possible relation to lead exposure. To activate the fields related to pottery and utensil exposures select “Yes” from the list of choices in the “Do you have any imported or handmade ceramics in the household?” list box. Only list those items which the patient comes into contact.



Input data related to the family’s use of possible lead containing pottery and utensils in user form near bottom of page.

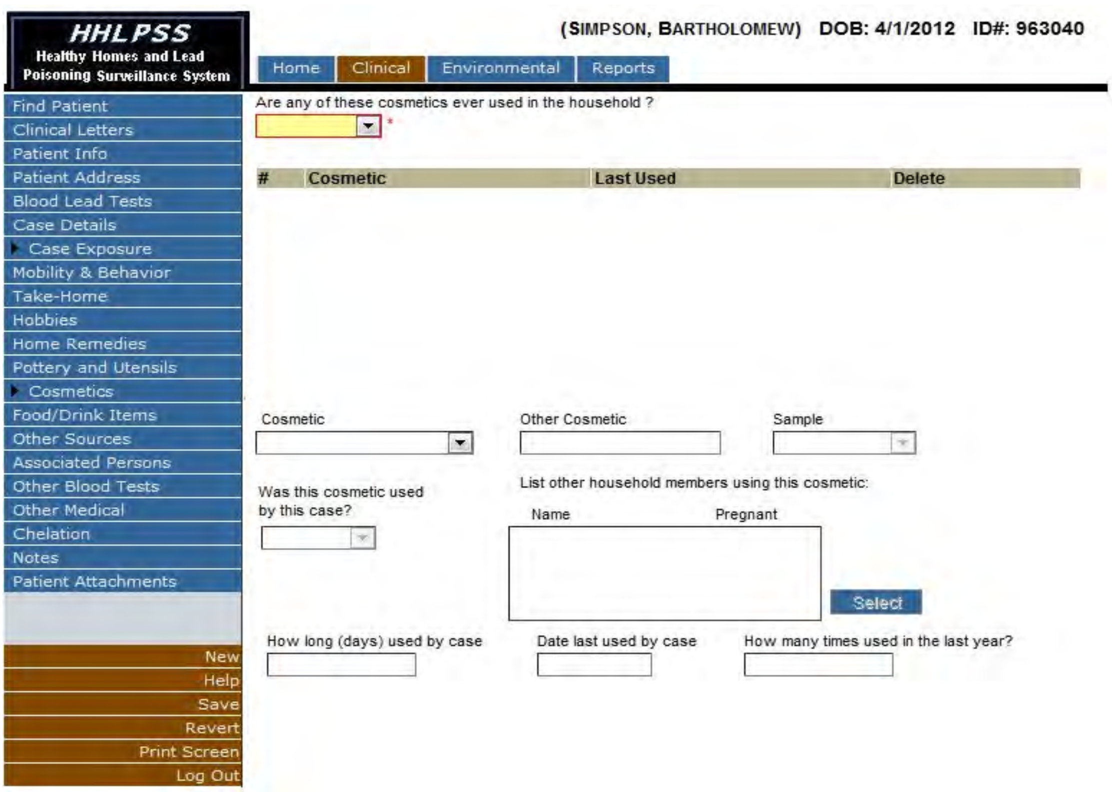
The only field required to create a pottery/utensil exposure record is displayed with a red asterisk [*] and is Imported or handmade ceramics.

Input the corresponding data in the required and other fields corresponding for the new home remedy and click the “Save” button in the (burgundy) bottom left corner menu to save record.

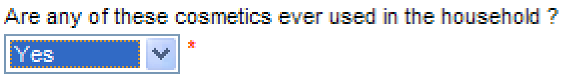


Cosmetics

To input details relating to the patient’s exposures to lead sources during the use of cosmetic products, utilize the “Cosmetics” menu item of the “Clinical” tab.



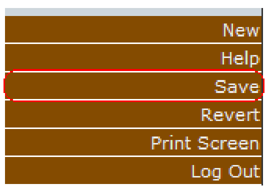
The “Cosmetics” exposure page allows the user to input details related to the cosmetic products utilized by the patient’s family and their possible relation to lead exposure. To activate the fields related to pottery and utensil exposures select “Yes” from the list of choices in the “Are any of these cosmetics ever used in the household?” list box.



Input data related to the family’s use of possible lead containing cosmetic products in user form near bottom of page.

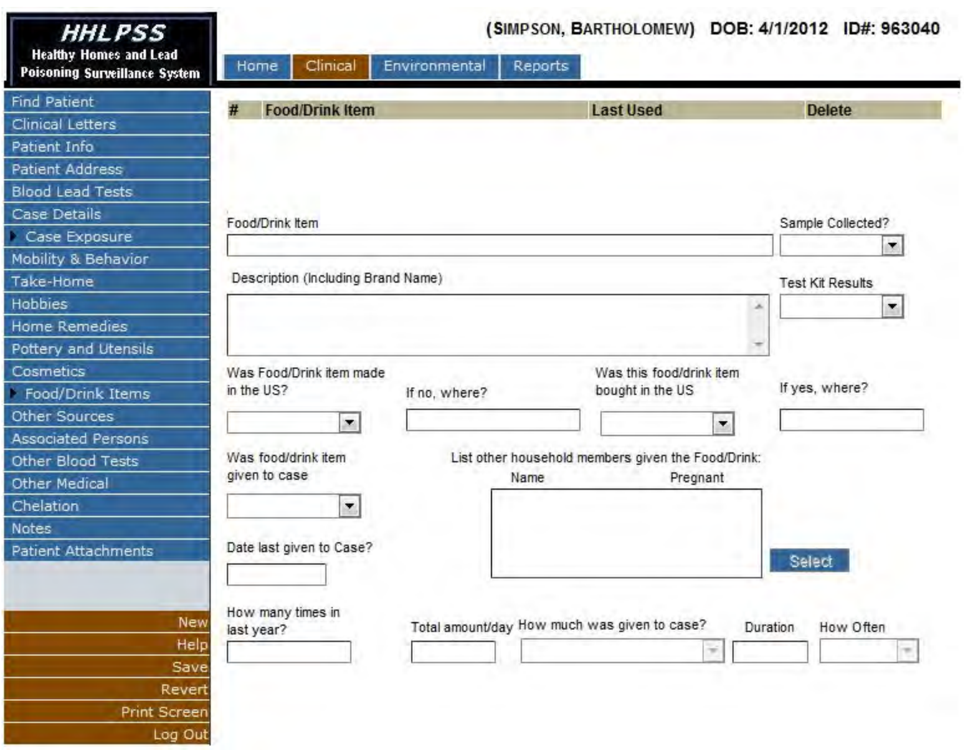
The only field required to create a pottery/utensil exposure record is displayed with a red asterisk [*] and is Cosmetic. If “Other Cosmetic Type” is chosen, a description must be supplied in the “Other Cosmetic” text box.

Input the corresponding data in the required and other fields corresponding for the new cosmetic product and click the “Save” button in the (burgundy) bottom left corner menu to save record.



Food/Drink items

To input details relating to the patient’s exposures to lead sources during the use of certain food or drink items, utilize the “Food/Drink items” menu item of the “Clinical” tab.

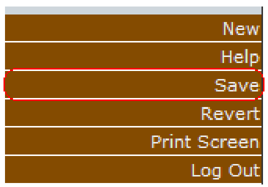


The “Food/Drink items” exposure page allows the user to input details related to the food or drink products utilized by the patient’s family and their possible relation to lead exposure.

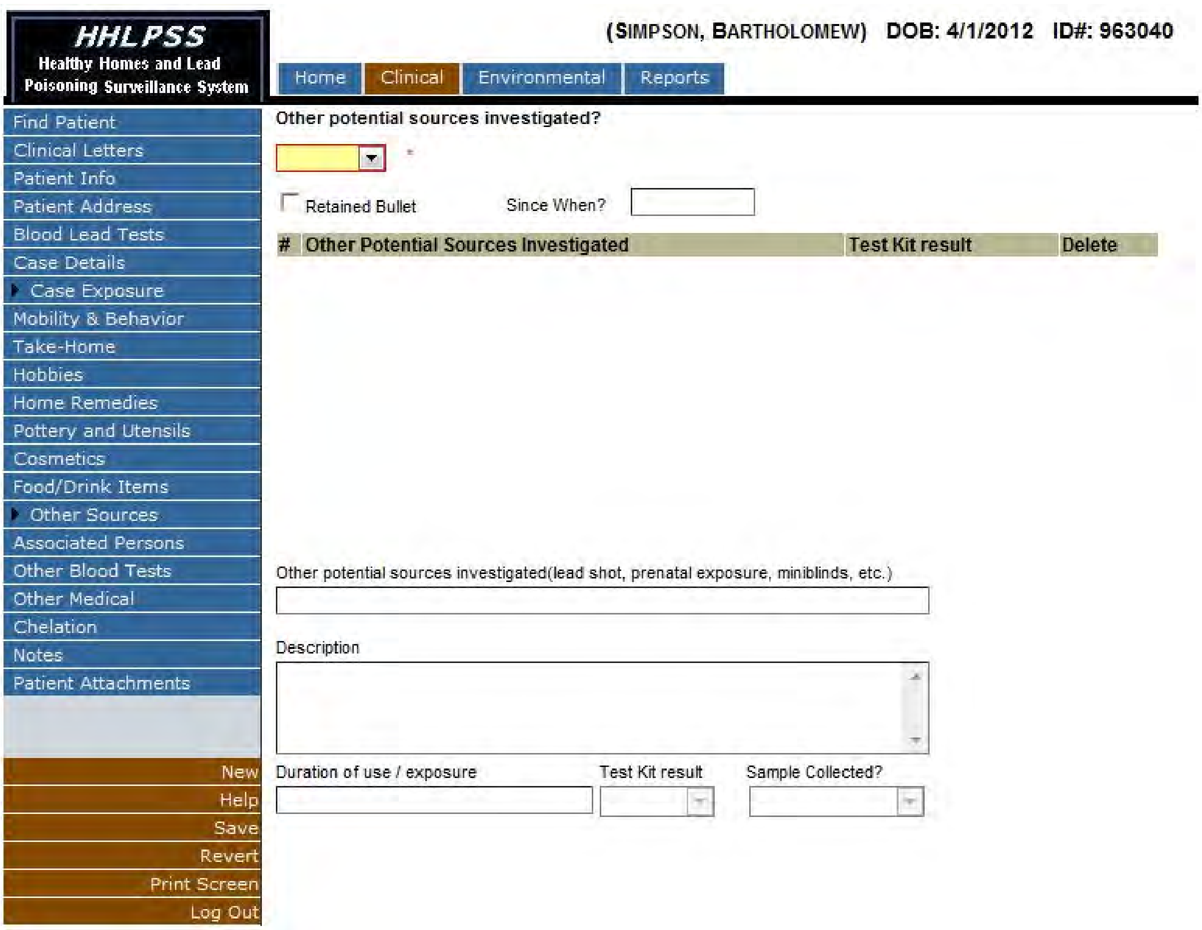
Input data related to the family’s use of possible lead containing food or drink products in user form near bottom of page.

The only field required to create a pottery/utensil exposure record is displayed with a red asterisk [*] and is Food/Drink Item.

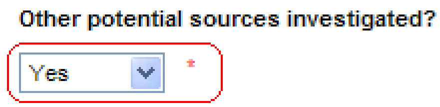
Input the corresponding data in the required and other fields corresponding for the new cosmetic product and click the “Save” button in the (burgundy) bottom left corner menu to save record.



Other Sources
To input details relating to the patient’s exposures to lead sources not currently classified within the system, utilize the “Other Sources” menu item of the “Clinical” tab



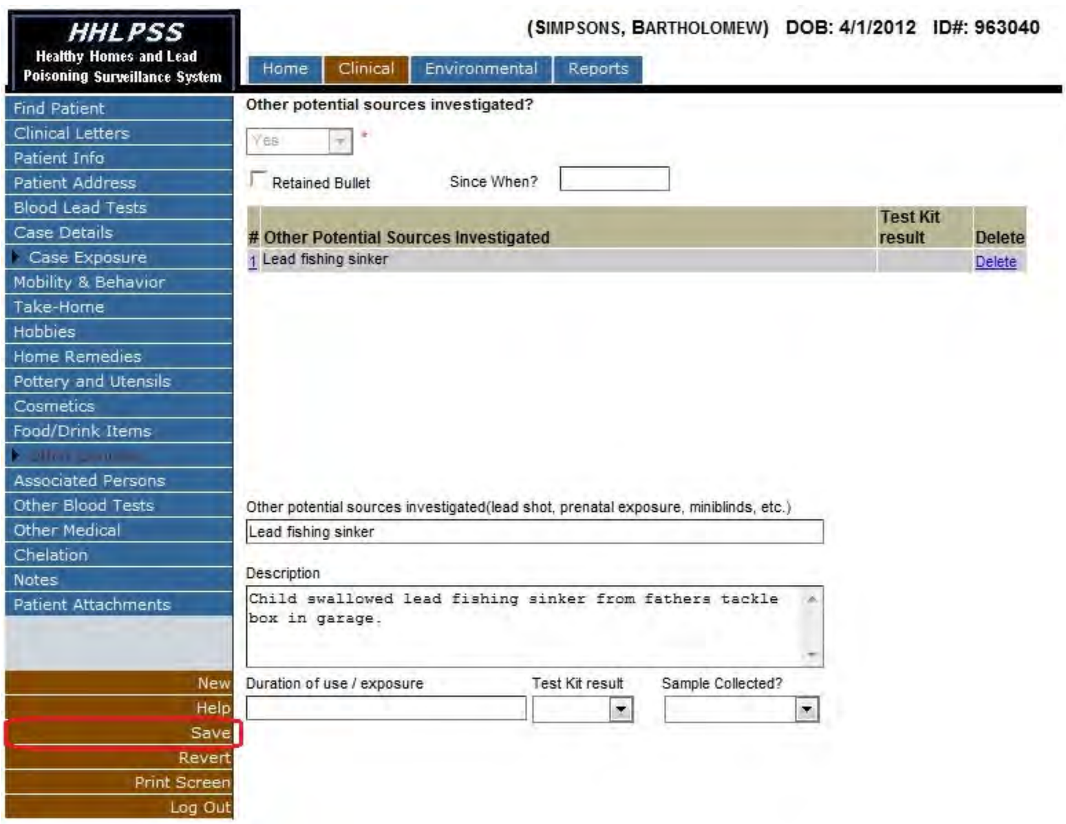
The “Other Sources” exposure page allows the user to input details related to lead sources not currently classified within the system and their possible relation to lead exposure. To activate the fields related to “other source” exposures select “Yes” from the list of choices in the “Other potential sources investigated?” list box.



Input data related to the family’s use of possible lead containing substances in user form near bottom of page.

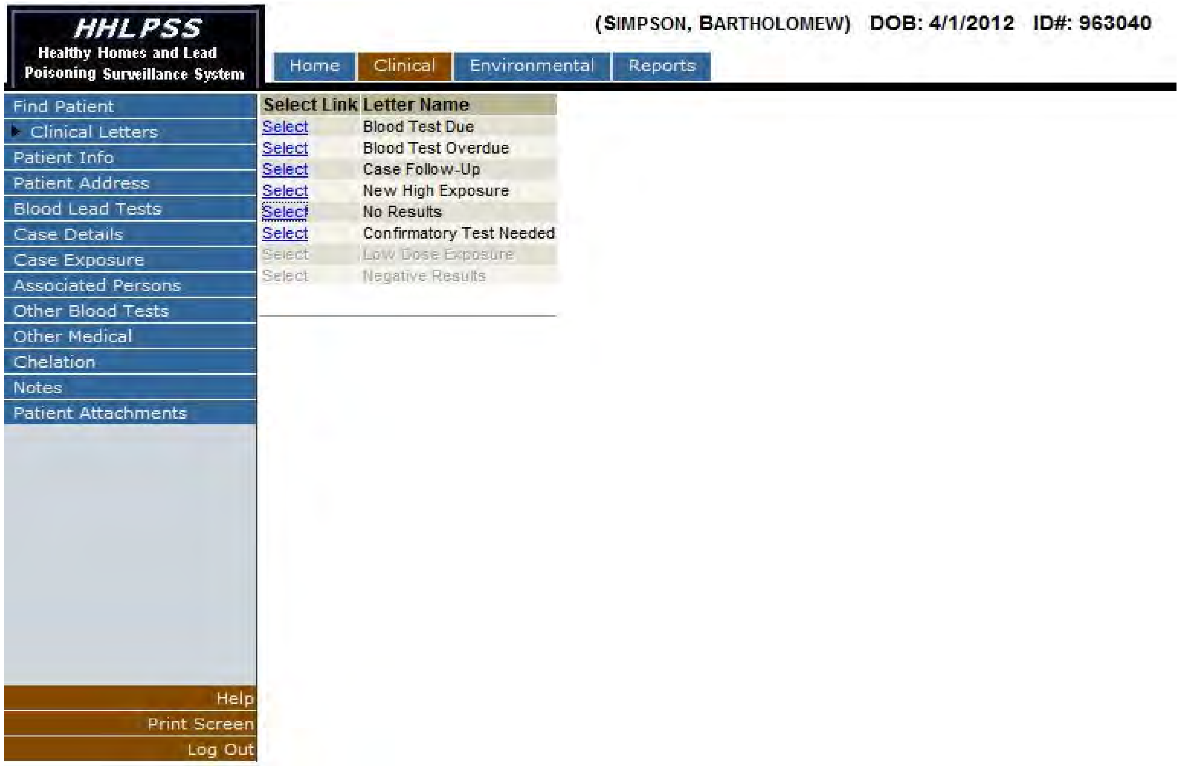
The only field required to create a pottery/utensil exposure record is displayed with a red asterisk [*] and is Other potential sources investigated.

Input the corresponding data in the required and other fields corresponding for the new possible lead source and click the “Save” button in the (burgundy) bottom left corner menu to save record.



Clinical Letters

The “Clinical Letters” page allows the user to view and edit selected letter templates for patient communications. The page contains a tabular listing of the letter templates available within the system for automatic generation.

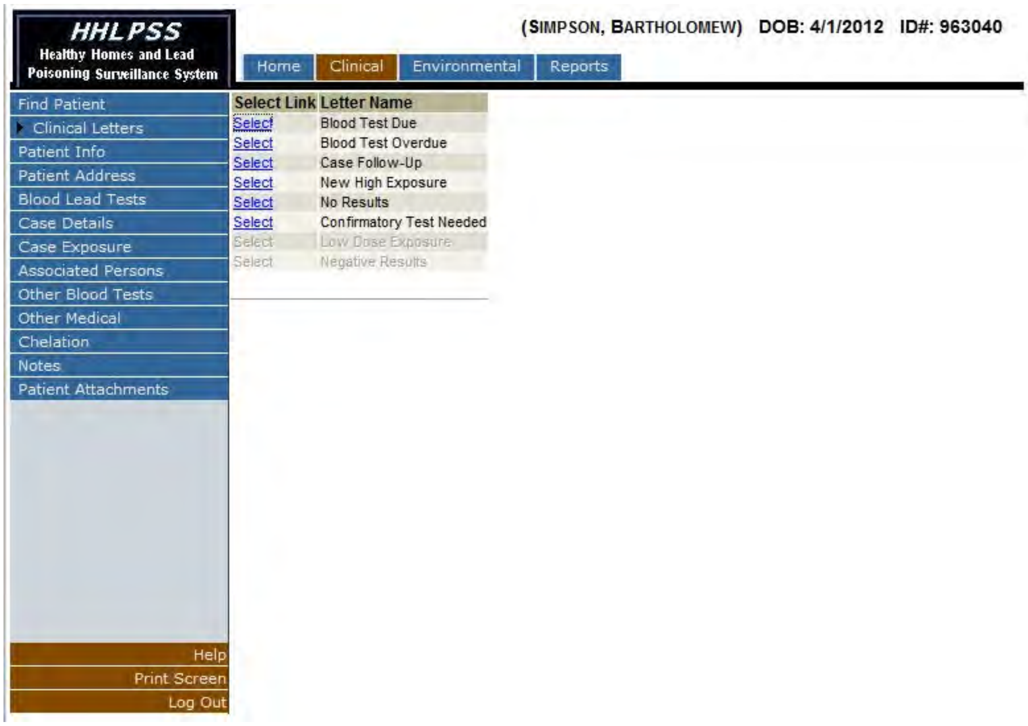


Clinical letters can be downloaded and edited by clicking the ‘Select’ hyperlink corresponding to the row of the desired letter in the letter listing table.

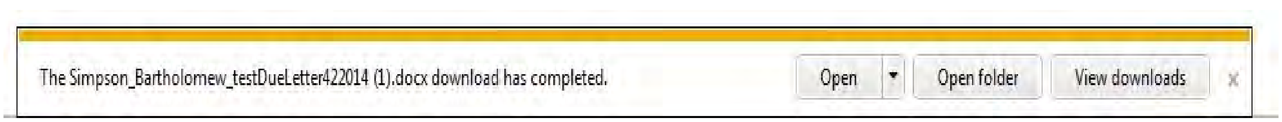
Letter Name	Case Availability	Description
Blood Test Due	Yes	Sent as a reminder of approaching recommended blood lead re-testing date.
Blood Test Overdue	Yes	Sent as a reminder of overdue blood lead re-test.
Case Follow-Up	Yes	Sent to inform patient/guardian(s) of initial case, follow-up testing levels and next recommended blood lead testing date.
New High Exposure	Yes	Sent to inform patient/guardian(s) of newly processed case-level blood lead result and next recommended blood lead testing date.
No Results	Yes	Sent to inform patient/guardian(s) of newly processed blood lead test without result level and next recommended blood lead testing date

Confirmatory Test Needed	Yes	Sent to inform patient/guardian(s) of the need to confirm previously received blood lead result with a new test and the recommended blood lead testing date.
Low Dose Exposure	No	Sent to inform patient/guardian(s) of a newly processed 'low' blood lead testing result and the recommended next blood lead testing date.
Negative Results	No	Sent to inform patient/guardian(s) of a newly processed 'negative' blood lead testing result and the recommended next blood lead testing date.

The letter template will be populated with data related to the selected patient and made available for download for the user.



Click the 'Open' button to open the document for immediate editing. Click the 'Save' button, to save the document to local file storage for later use.



New High Exposure Letter

4/4/20144/4/20144/4/2014

To the parent or guardian of

Bartholomew Simpsons

321 E 12th ST

Des Moines IA 50319

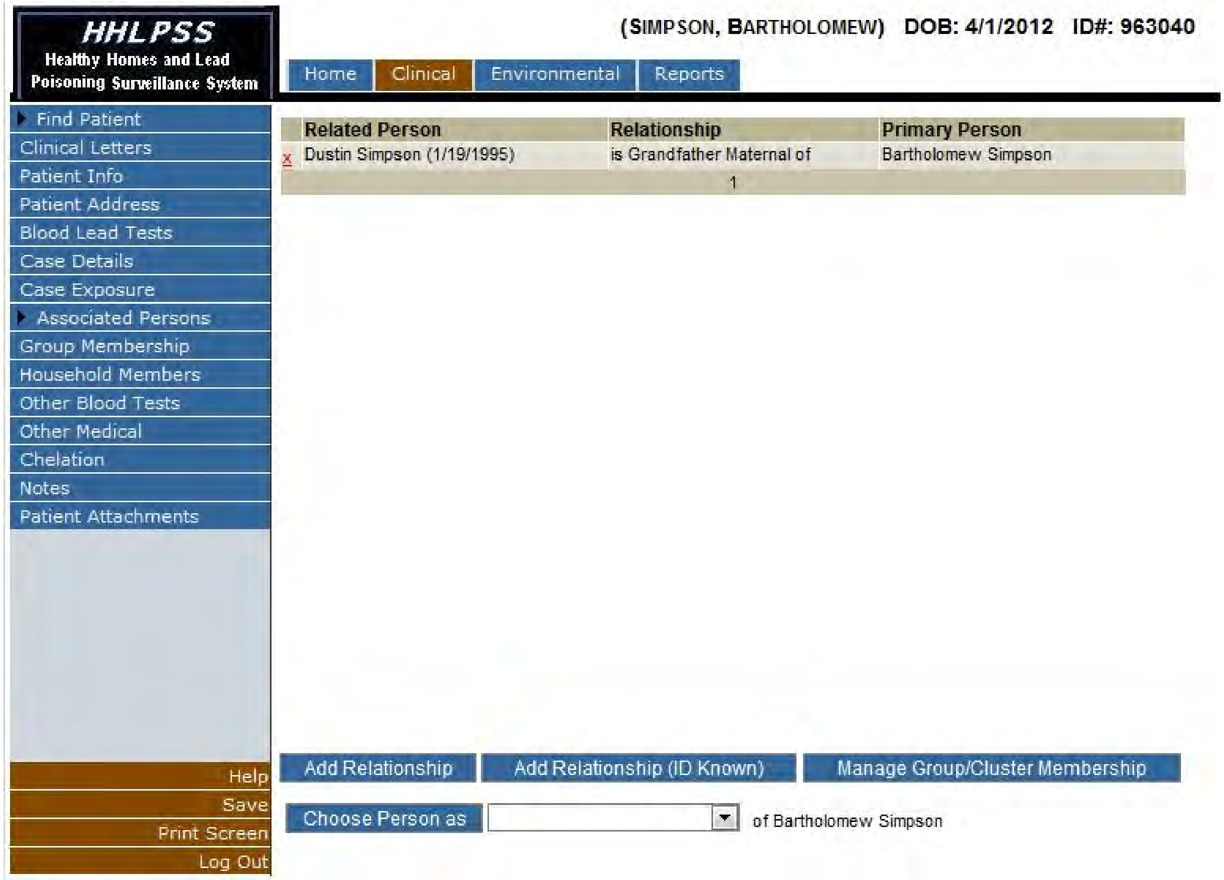
Your Child was tested for lead poisoning on 4/1/2013. The result of this test was a level of 32.00. This means that your child may have LEAD POISONING, a serious illness which can cause behavior and learning problems. Another blood lead test should be performed on or before 4/29/2013 to make sure the blood lead level has not gotten any higher. Make an appointment with your child's doctor as soon as possible so that your child may be evaluated for lead poisoning. Show this letter to your child's doctor as a record of the test level.

Sincerely yours,

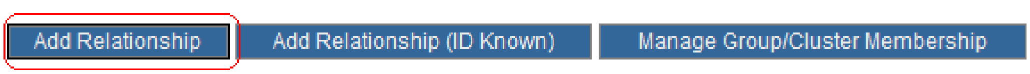
State CLPPP

Associated Persons

To view and details relating to a patient's relationship to other persons and groups listed within the system utilize the "Associated Persons" menu item of the "Clinical" tab. Previously entered family members and guardians should be present within the listing

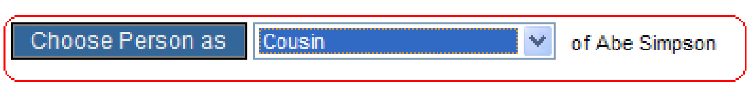


To associate a patient with another patient record within the system, click the "Add Relationship" button near the bottom of the "Associated Person" screen.

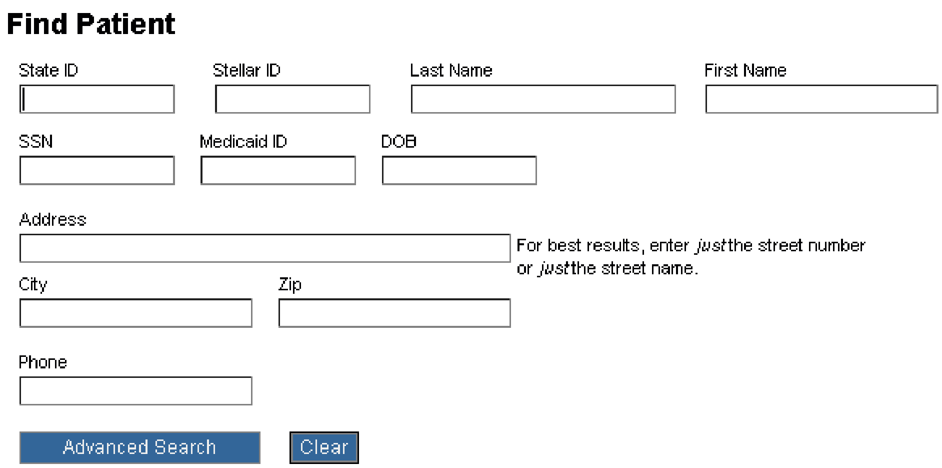


This will activate the "Choose Related Person" controls within the page.

Select the relationship of the person to the patient from the selection list and click the "Choose Person as" button.



This will activate the "Find Patient" screen.



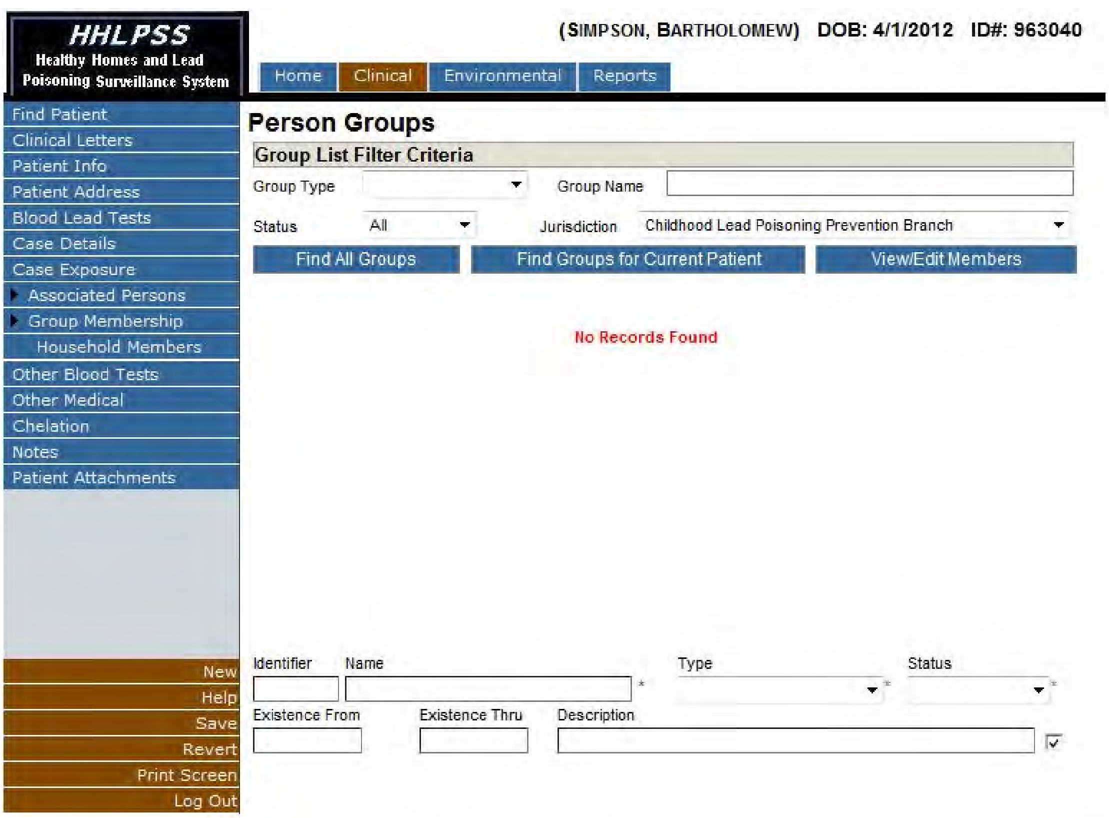
Input search criteria to match the patient you wish to associate with the current patient.

Select the related patient in the search results list (if the desired relation is not within the list, they are not currently in the system as a patient).

The patient will be associated with the current patient.

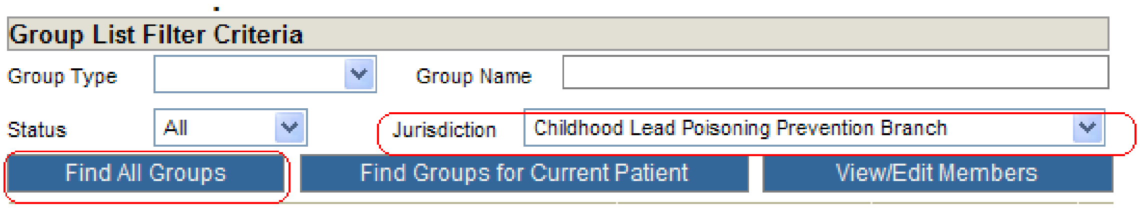
Group Membership

To manage and associate groups of patient records, utilize the “Group Membership” menu item in the “Associated Persons” sub menu in the “Clinical” tab.



Patients can be added or removed from person groups in the “Group Membership” screen.

First, search for or create a new group utilizing the “Group List Filter Criteria” controls near the top of the form (group search) and the user form near the bottom of the form (group creation).

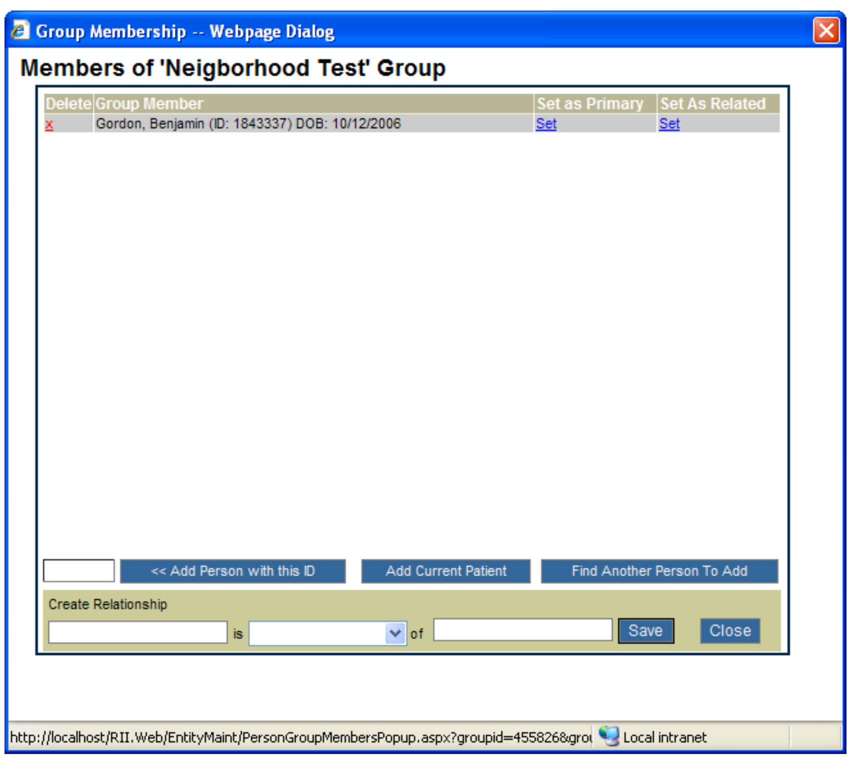


To search for a group, select a Jurisdiction for the group and click the “Find All Groups” button. This will list all of the groups created within the selected jurisdiction in the group selection list

Select	Group Name	Group Type	Status	
455826	Neigborhood Test	Other	Active	X

Select a group by clicking the identifier number link in the “Select” column of the group listing. To view or edit the members of the group click the “View/Edit Members’ button under the “Group List Filter Criteria” area near the top of the form.

This will activate the Group Membership Popup.



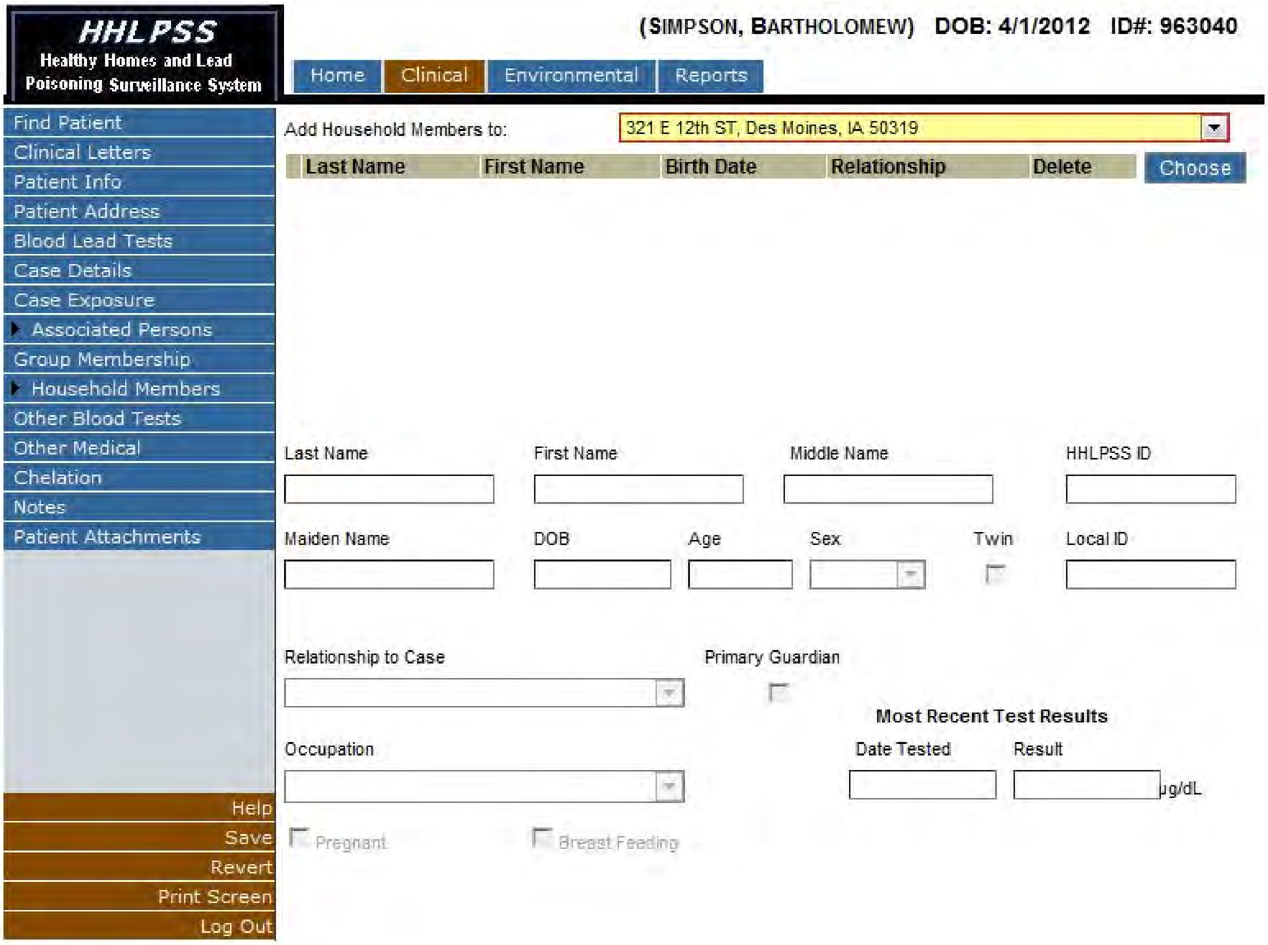
To add the current patient to the group, click the “Add Current Patient” button.

To add a different patient to the group, click the “Find Another Patient” button, this will activate the find patient popup and allow you to search for another patient to add to the group.

If you happen to know the identifier number of the patient you wish to add to the group, input it into the text box next to the “Add Patient with the ID” button and click the button.

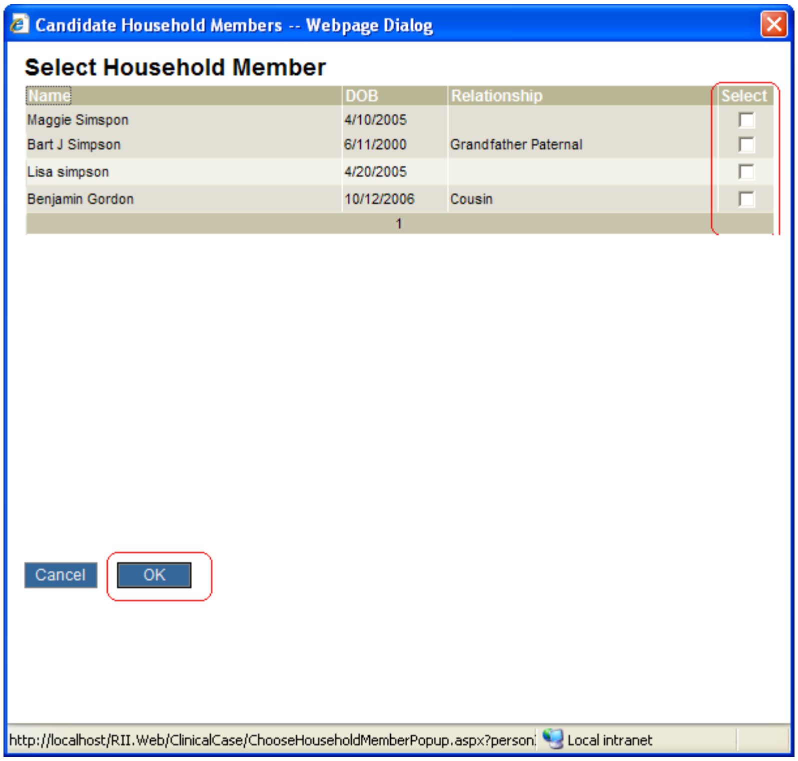
Household Members

To add additional detail to patient family member records, utilize the “Household Members” menu item in the “Associated Persons” sub menu in the “Clinical” tab.

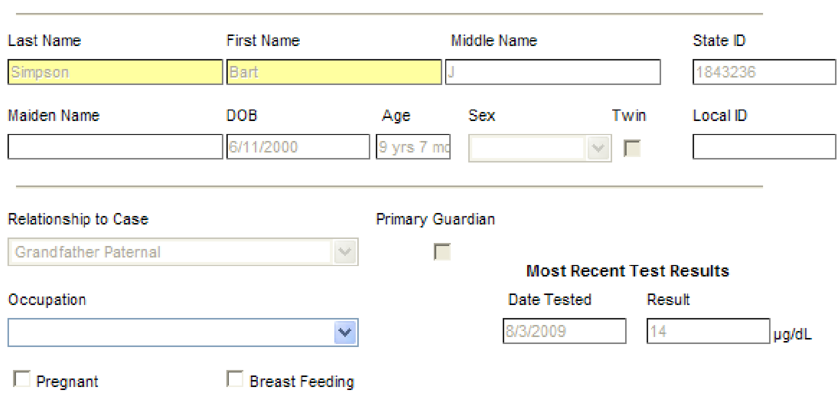


To add additional details to patient family member records, click the “Choose” button near the top of the page to select a family member.

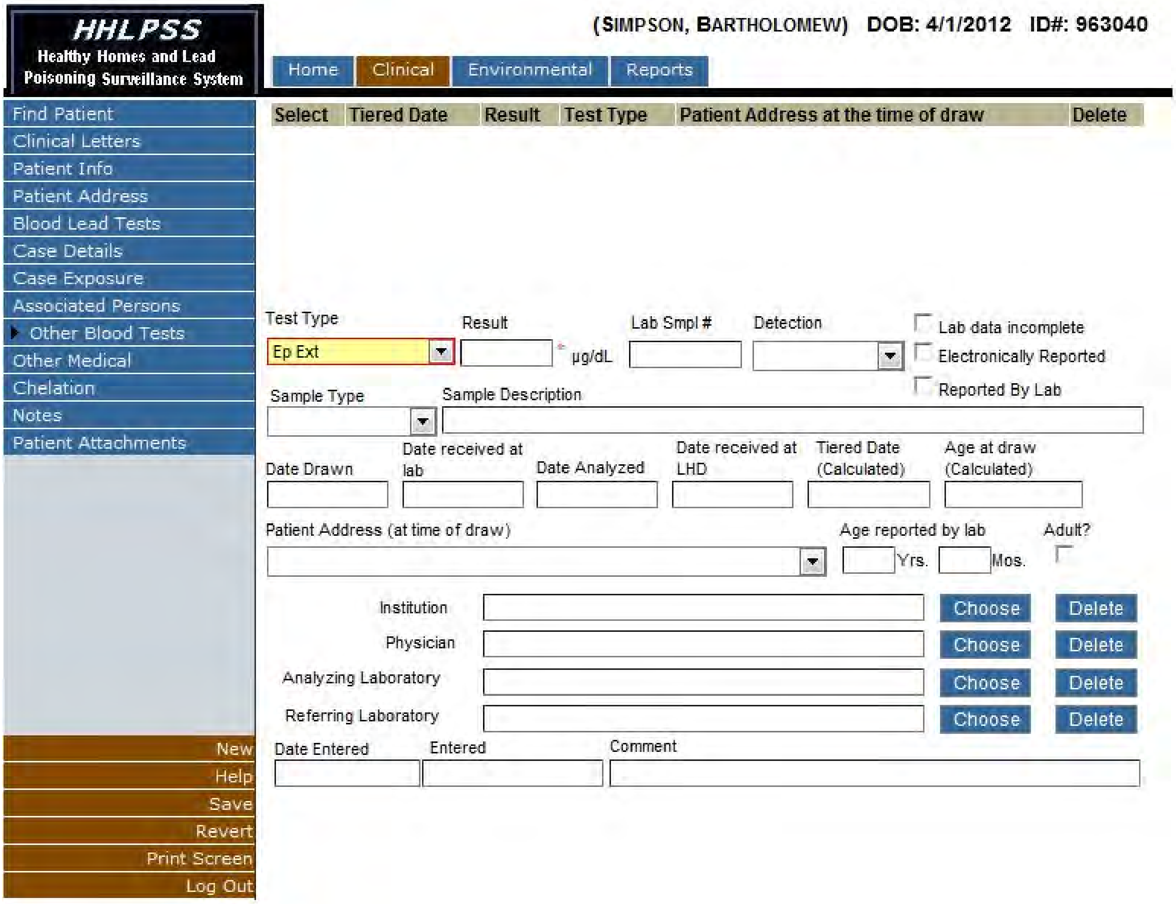
This will activate the “Select Household Member” popup. You can select family members to edit by clicking the corresponding checkboxes next to their name in the popup list. Click “OK’ to close the window.



After the selection has been completed, you can add additional details for any family member by clicking the "Select" link next to their name in the household member listing and editing their details in the user form near the bottom of the page.



Other Tests



The Patient Other Blood Test History Screen will be utilized to view and input details related to the selected patient's lab testing history (non-blood lead tests).

The earliest test available will be selected in the test list and active within the user form below the test list.

Other Blood Test User Form Field Listing

Field Name	Meaning
Test Type – non blood lead tests	Type of laboratory test (i.e. EP Ext)
Result	Result value of test
Lab Sample Number	Sample number assigned by laboratory
Detection	Results value comparator (=, >, <)
Lab data incomplete	Indicates whether the blood lead test is missing data
Electronically Reported by Lab	Indicates whether the record was electronically reported
Sample Type	Sample the type reported by lab (i.e. venous, capillary, or unknown)
Sample Description	Free text a description of blood tests in the
Date Drawn	Date sample was drawn from patient
Date received at lab	Date laboratory received sample from provider
Date received at the local health departments (LHD)	Date blood lead test record was received by State or Local health department
Tiered Date (System Calculated)	Date utilized to calculate date ranges base upon dates associated with address (set to Date Drawn if available)
Age at draw (System Calculated)	Age of patient at date drawn
Patient address	Choose the address of the patient associated with blood test.
Adult indicator	Indicates whether the patient should be considered an adult
Institution	Institution where sample was provided (hospital or clinic)
Physician	Provider who drew or recommended blood lead test
Analyzing laboratory	The laboratory which analyzed the sample.
Referring laboratory	The laboratory which referred the sample to analyzing lab.(if necessary)
Comment	Free text comments
Date created	The date blood test record was created (system generated)
Created by	User who created blood test record (system generated)
Date modified	Date blood test record was modified (system generated)
Modified by	User who modified blood test record (system generated).

The user can select any blood test within the listing of tests for the patient by clicking the test identifier number link in the “Select” column of the blood test list.

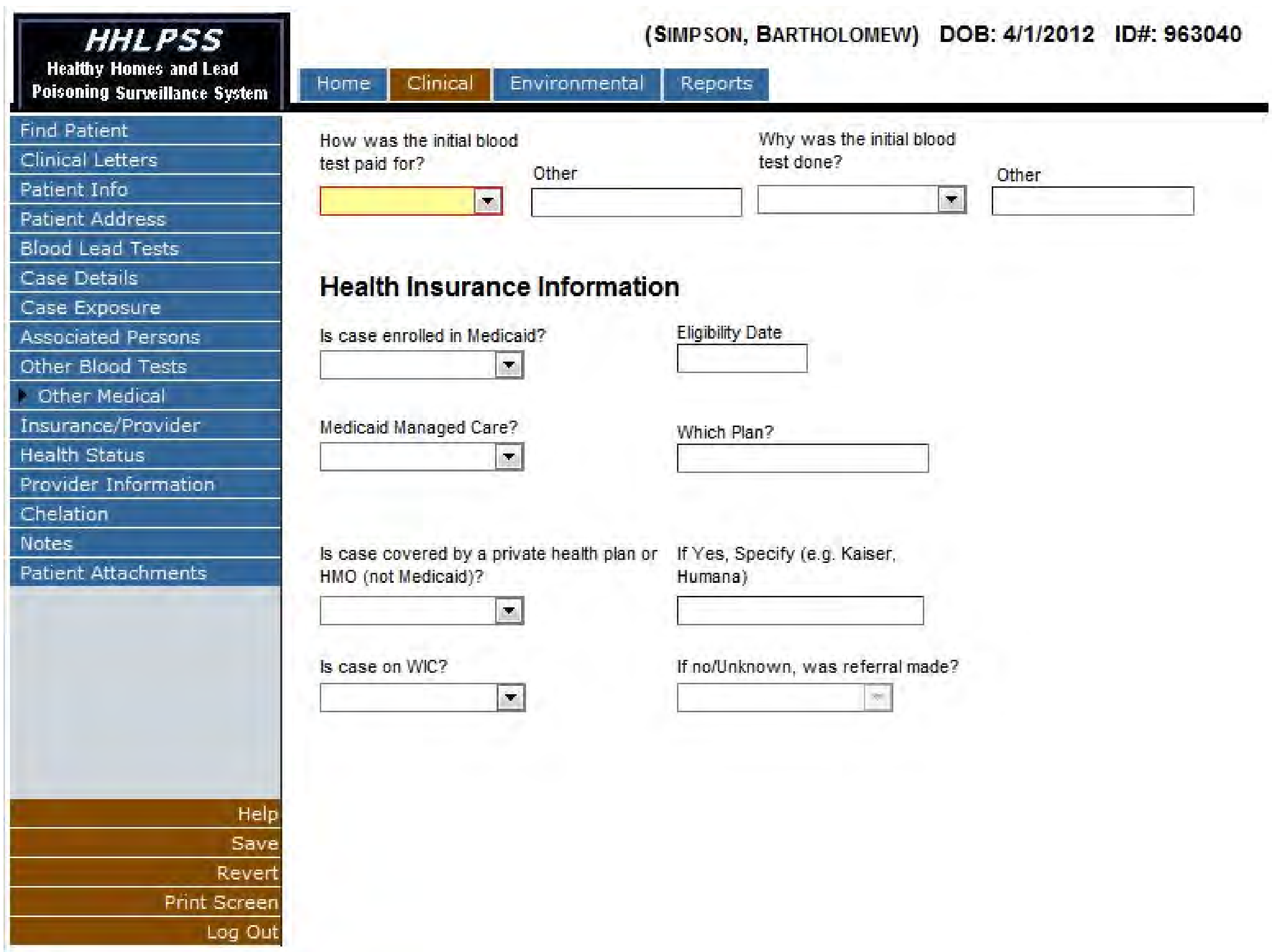
If you wish to delete any test within the listing, click the “Delete” link in the “Delete” column of the blood test list. (Case making blood tests cannot be deleted)

Directions to add or edit new records are identical to blood lead test history screens.

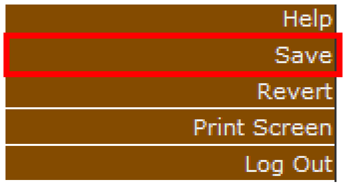
Other Medical

The “Other Medical” page is utilized to capture patient health insurance and blood test funding information. For patients with clinical cases, the system will allow for the collection of initial test funding information. Programs can track Medicaid enrollment and eligibility dates for patient, as well tracking the Medicaid managed care plan or private insurance provider for the applicable patient.

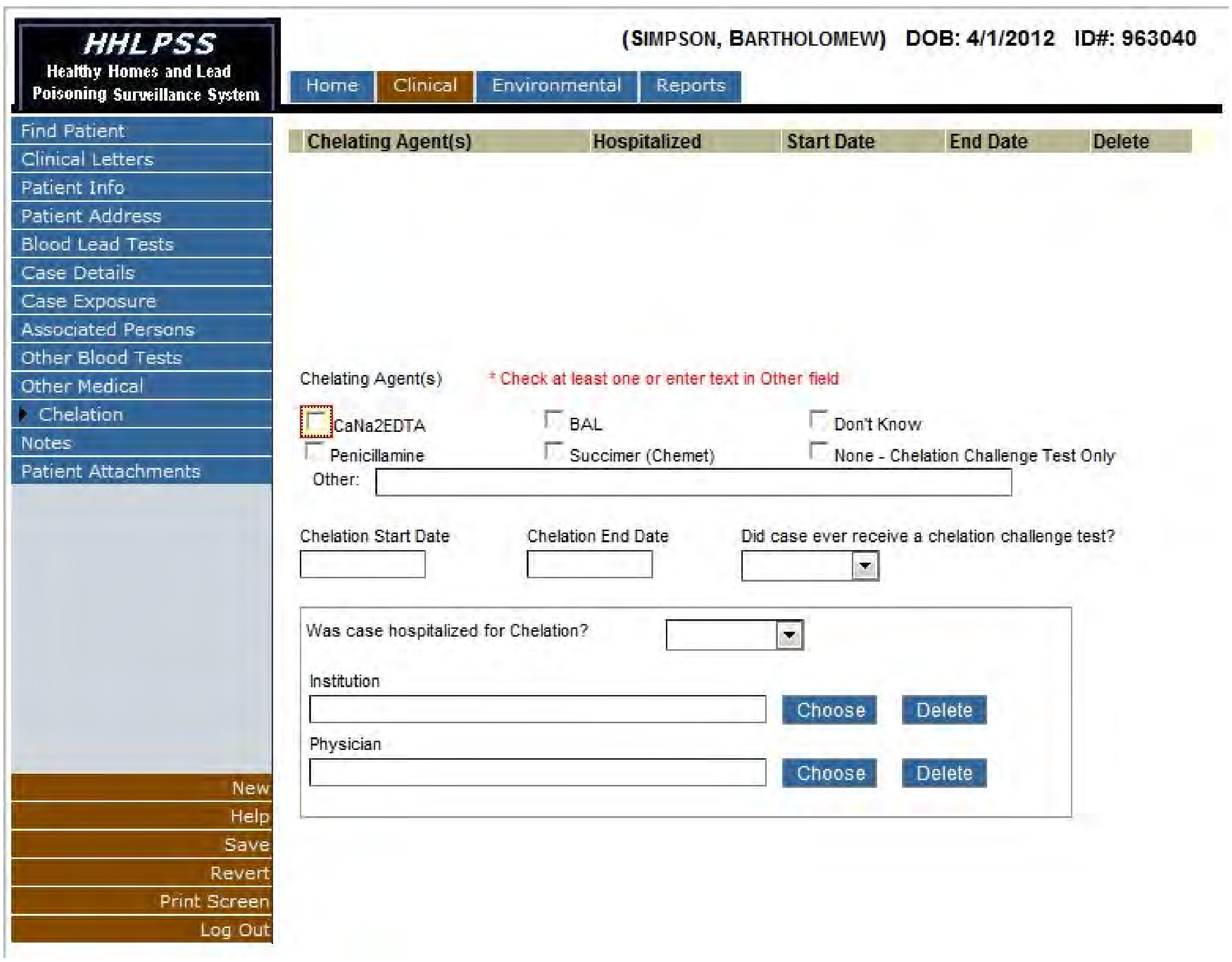
In addition, users can also track current WIC status and service referral date in the “Other Medical” page.



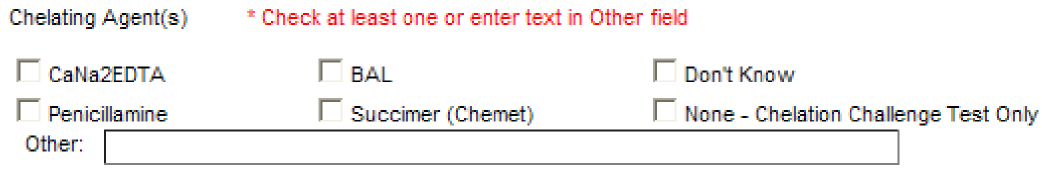
To add or update any of the information related to the “Other Medical” page. Make the appropriate selection in the relevant dropdown control () and if necessary, add the associated text to the corresponding textbox. After all selections are complete, click the “Save” button in the lower left hand Action menu of the HHLPSS page.



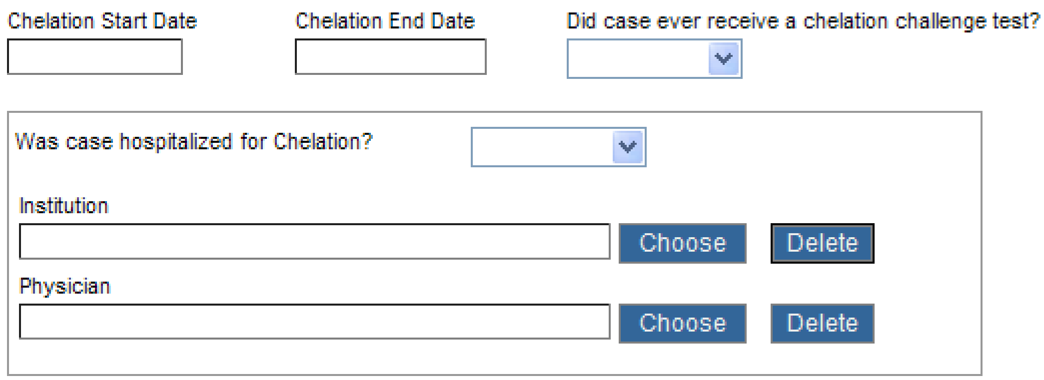
Chelation



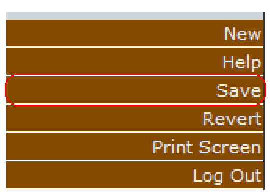
The “Chelation” page allows the user to input details related to the chelation treatments of lead poisoned patients with cases.



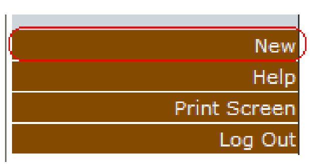
Select a chelating agent by checking one of the boxes next to the agent utilized for treatment or indicate the agent name in the Other text box if it does not exist in the list.



Input the remainder of the details of the treatment in the provider user form. To save, click the “Save” button in the (burgundy) bottom left corner menu to save the record.

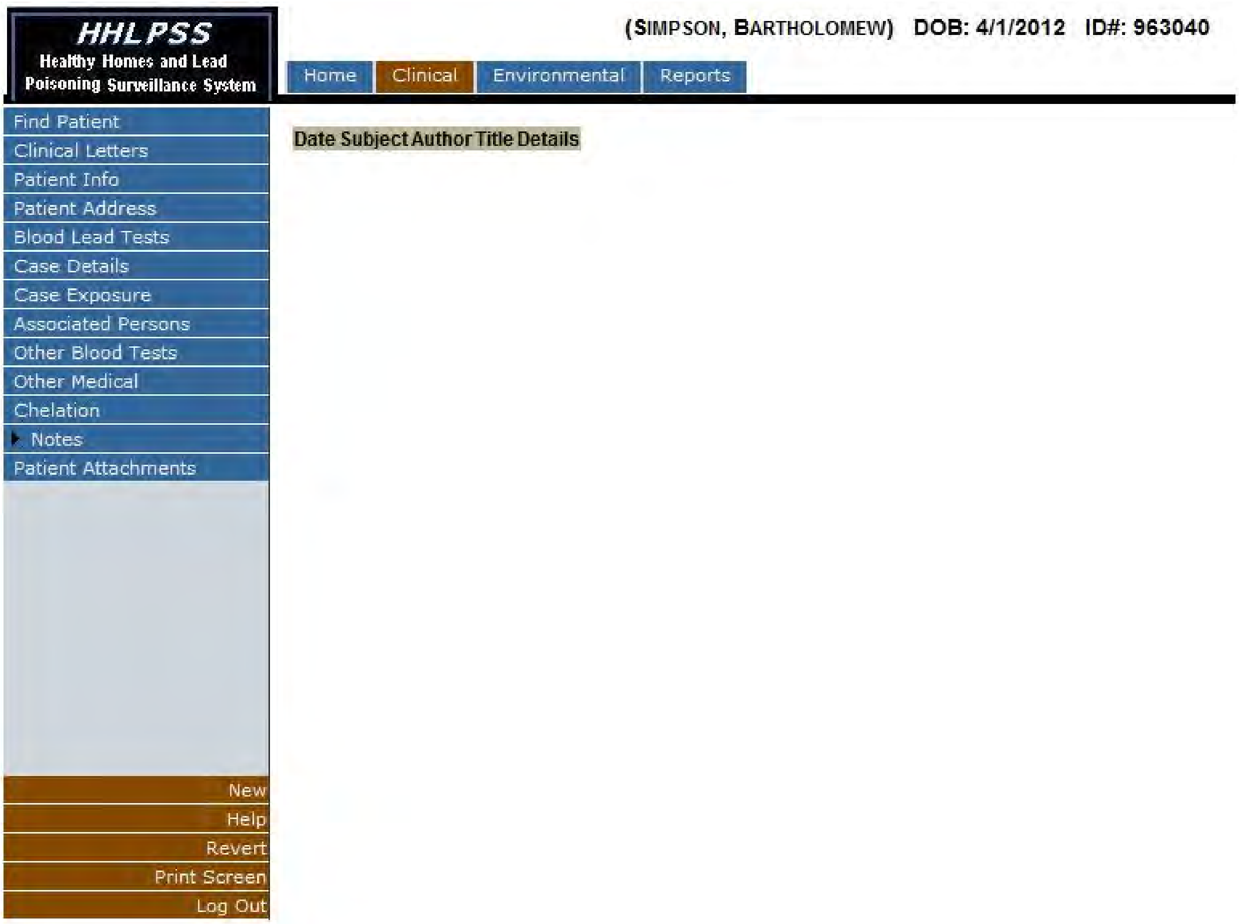


To add additional treatments, click the “New” button in the (burgundy) bottom left corner menu to prepare the form for record creation.



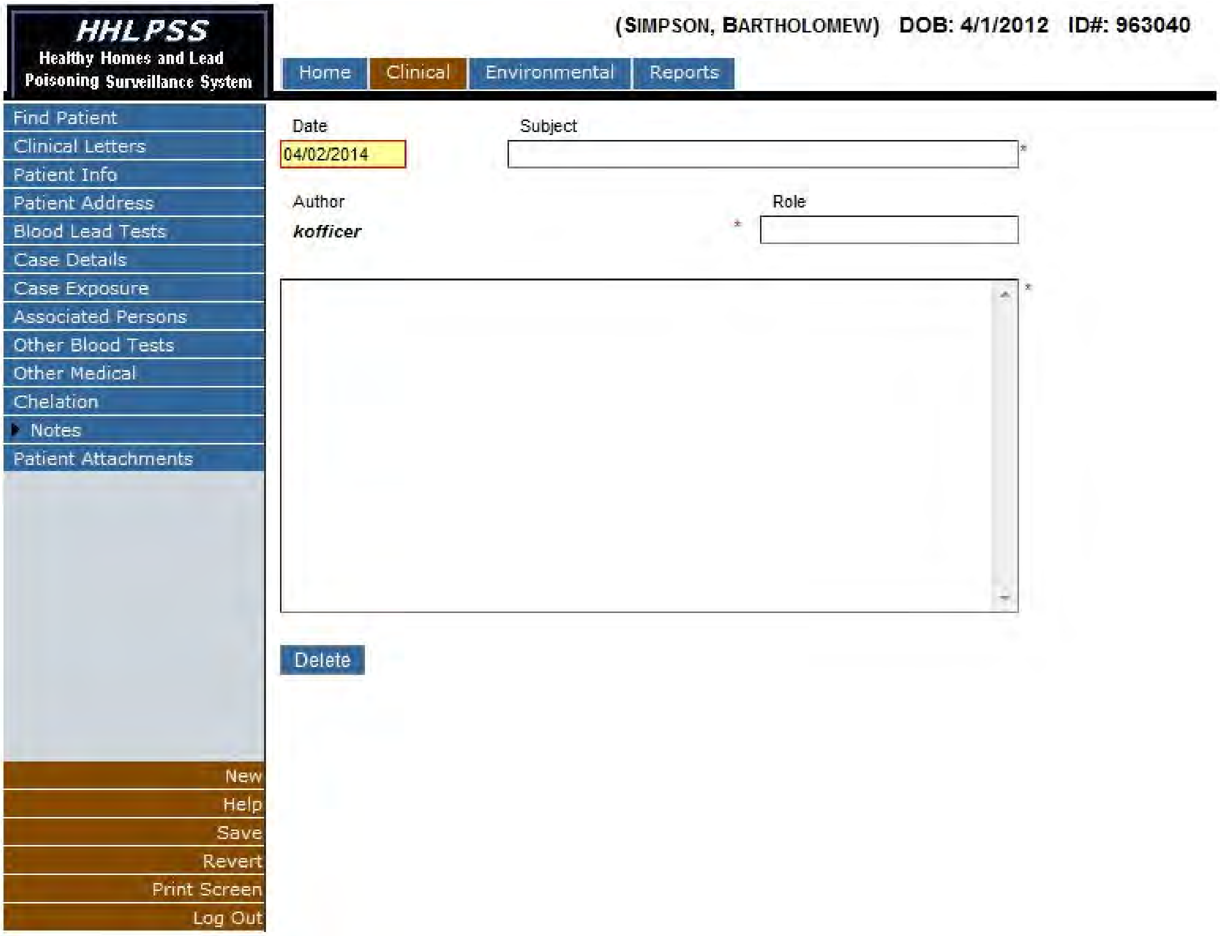
Patient Notes

The “Patient Notes” page allows the user to create custom free text notes which are associated with the patient record.



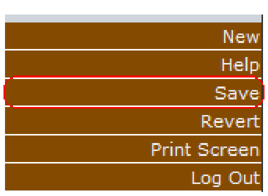
Existing patient notes will be listed within the Notes listing. To view or edit the details, click the “Detail” link in the “Details” column of the Notes Listing.

To add a new note to the note listing, click the “New” button in the (burgundy) bottom left corner menu to prepare the form for note creation.



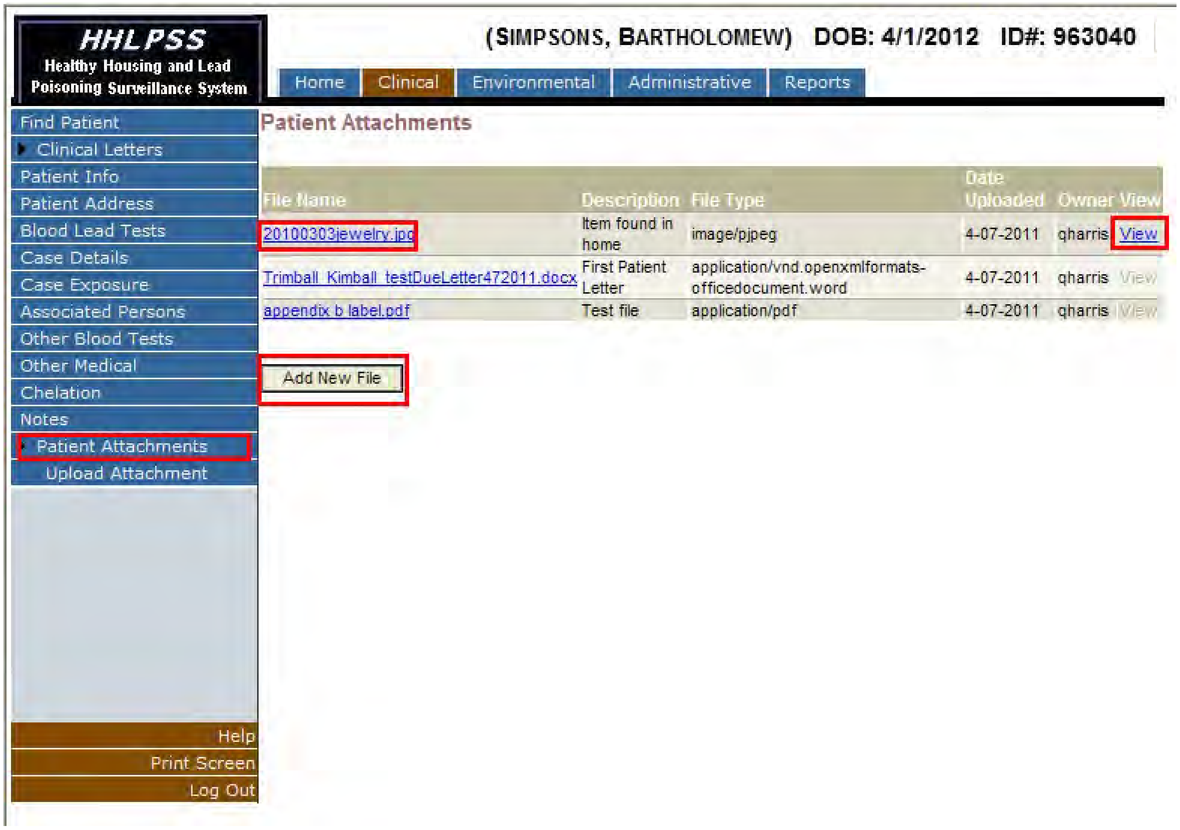
The minimum fields required to create a patient record are display with a red asterisk [*] and are Date, Subject, Author, and the actual contents of the note.

Input the corresponding data in the required and other fields corresponding to the new patient note and click the "Save" button in the (burgundy) bottom left corner menu to save the new patient note. After note creation, the note is added to the listing.



Patient Attachments

The “Patient Attachment” page allows the user to upload, download or view electronic files associated with the patient record.



Existing patient file attachments will be listed within the Patient Attachments listing.

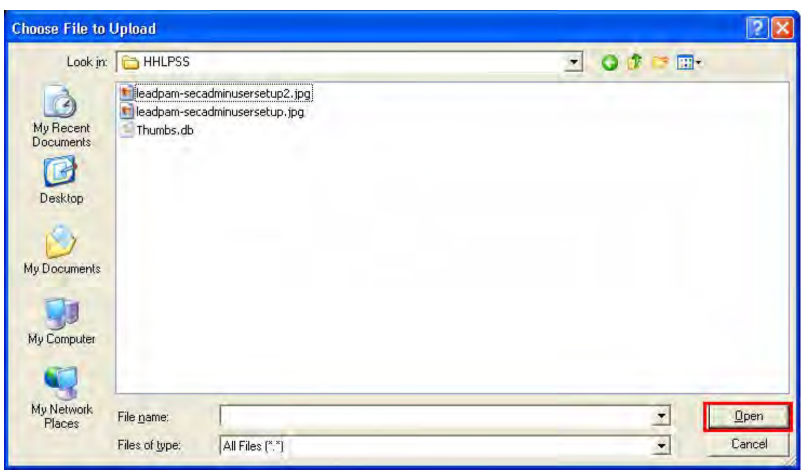
To download a file for viewing, click the “File Name” hyperlink in the “File Name” column of the Patient Attachments listing.

In cases where the file type is compatible, the file may be viewable within a browser window and the “View” hyperlink will be active within the “View” column of the Patient Attachments listing. Click the “View” hyperlink to launch a new browser window in which to view the electronic file.

To upload a new file attachment, click the “Add New File” button below the Patient Attachments listing.

A 'File Description' and selected file for upload is required to attach a file to the patient record.

Input the file description information and select a file for upload by clicking the "Browse" button.



Select a file and click the "Open" button in the choose file dialog box to prepare the file for upload. ***Files must be less than two (2) megabytes (MB – 2048 kilobytes [kb]) in size for proper attachment to patient record.*** Click the "Upload File" button once the file has been selected to add it to the Patient Attachment listing.

Environmental Investigations - Environmental Module

The Environmental module has been designed for viewing, editing or creating new patient address records as well as details related to environmental investigations.

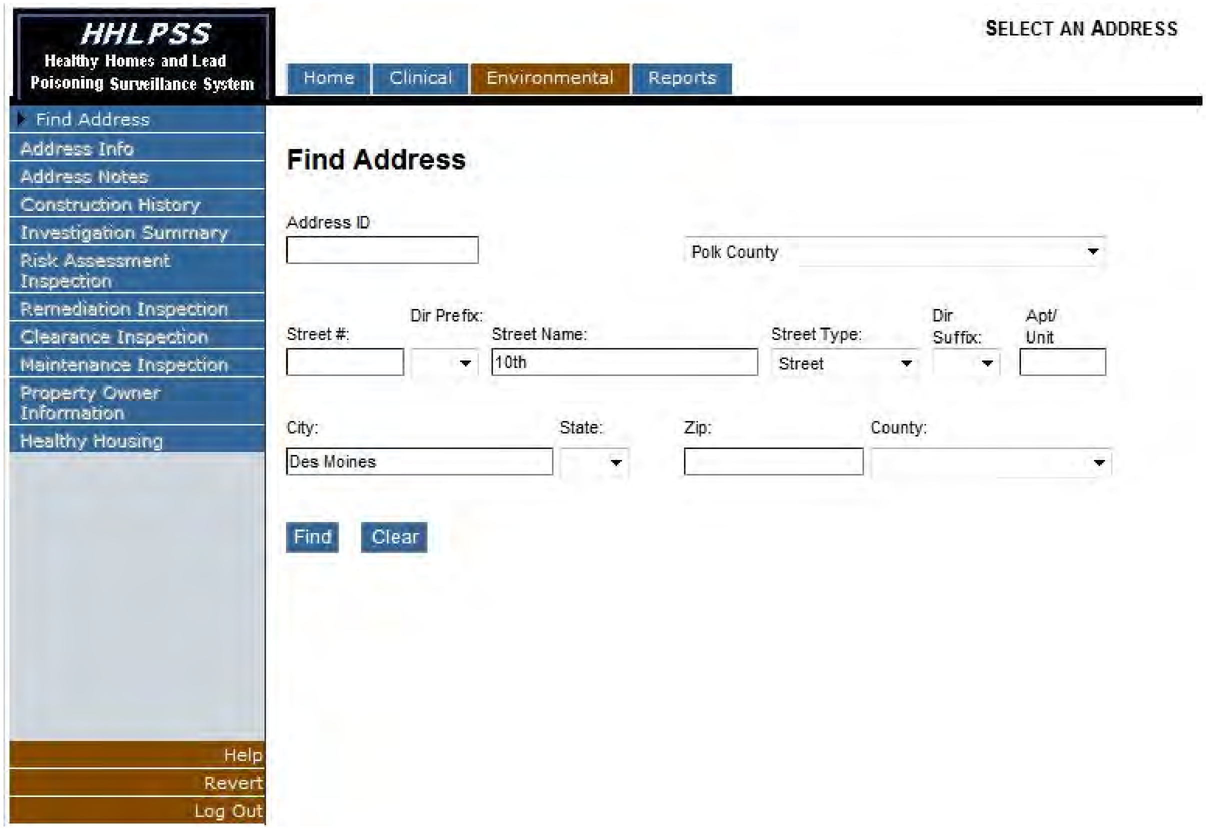
Edit or Add New Address

To view the details of a current address or to create a new address record within the system login to HHLPSS and select the Environmental Tab.

This will direct the browser to the "Find Address" screen.

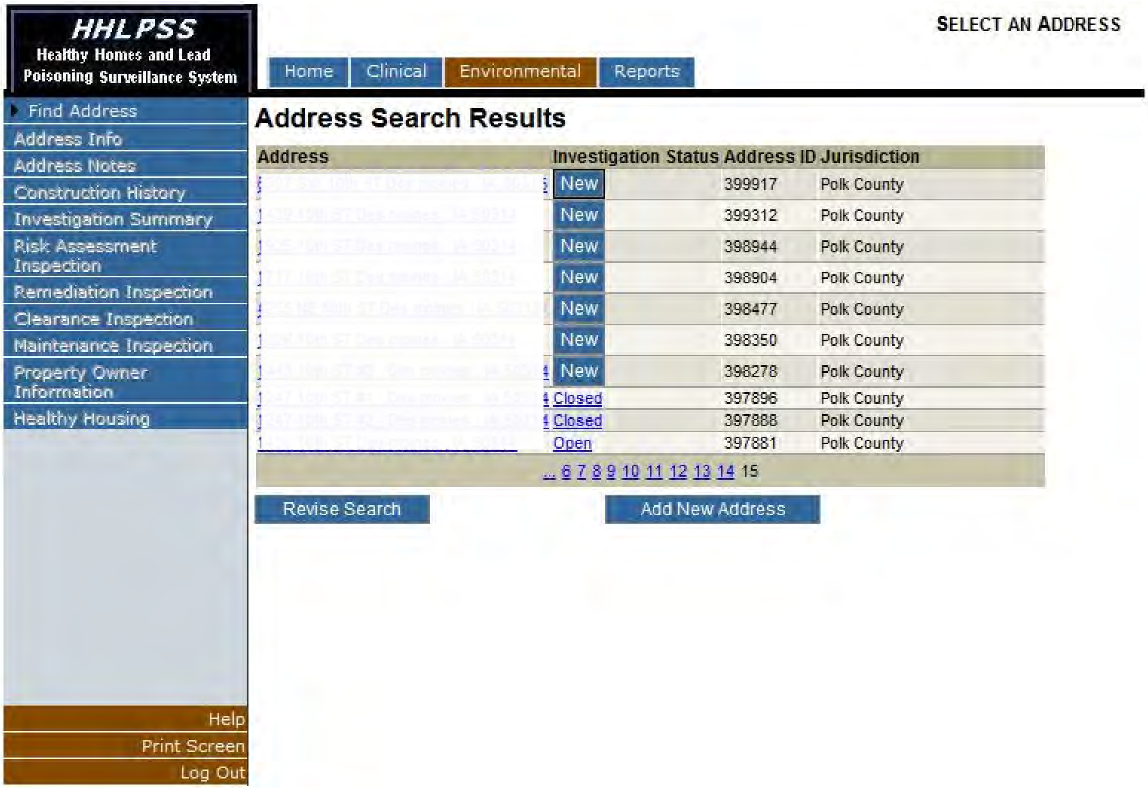
To prevent address duplication, prior to adding new data to HHLPSS you should perform a search for the address prior to receiving the option to create a new record.

Find Address

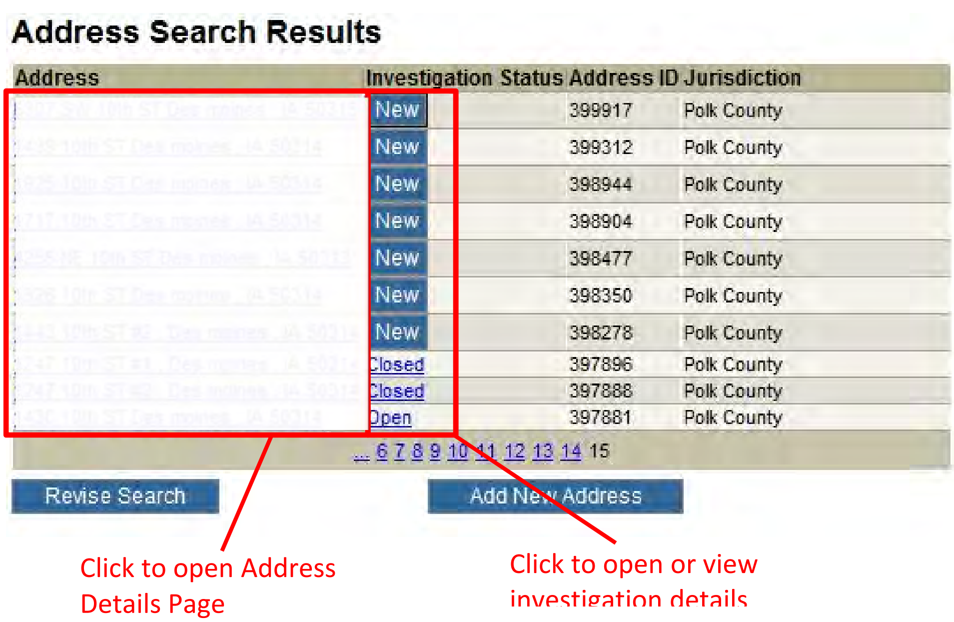


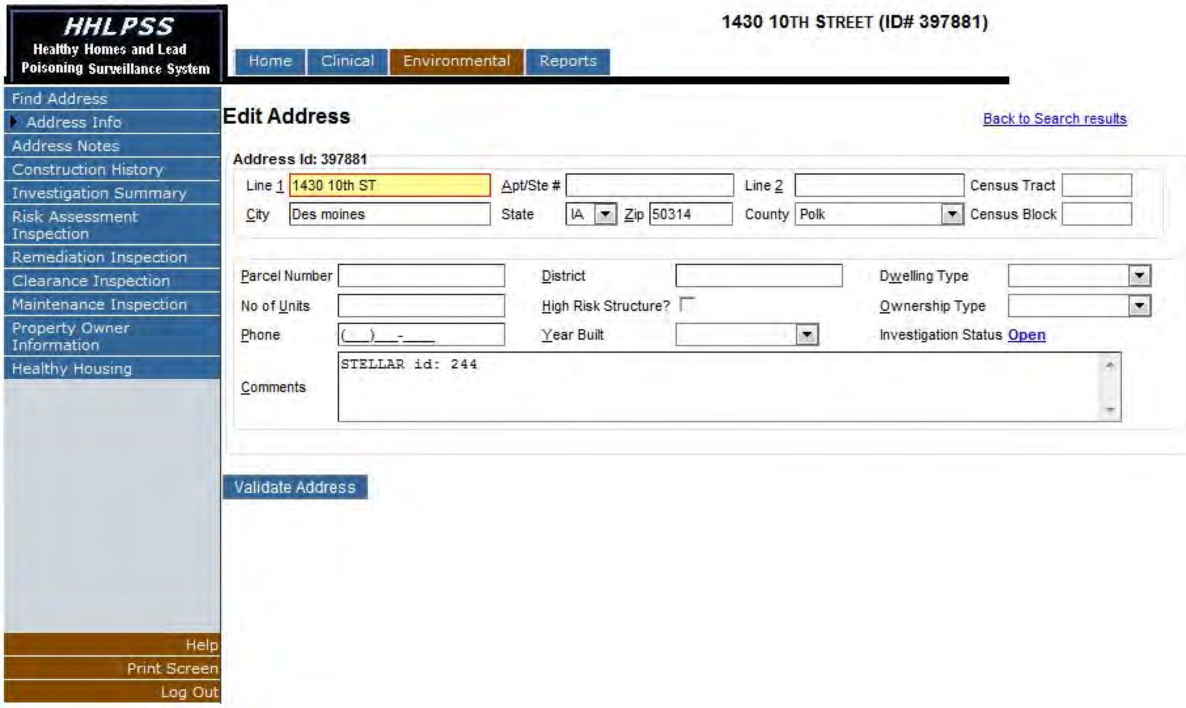
Perform a search on the first letter of the street and city names of the address you wish to create or find and click the "Find" button.

Address Search Results



If the address which you wish to create or edit is listed within search results, click the Address in the “Address” column to open the “Patient Address Details” screen





The Patient Address History Screen will be utilized to view and input details related to the selected patient's current and former addresses.

Address Details Form Field Listing

Field Name	Meaning
Line 1	Street Address
Line 2	Street Address Line 2
Apt/Ste #	Apartment or Suite Number
City	City
State	State
Zip	Zip Code
County	County
Investigation Status	Status of environmental investigation (open, closed, or new button to create investigation record)
Census Tract Number	Address census tract
Parcel Number	Local parcel number of address
District	Address district
High Risk structure indicator	Was the dwelling built prior to 1978
Dwelling Type	Selected dwelling type (Single, multi-family, etc.)

Field Name	Meaning
Number of Units	If multi-unit dwelling, number of units within dwelling
Phone	Contact phone number for owner of address
Ownership Type	Ownership type of residence (Owner occupied, rental, etc.).
Year Built	Approximate construction date of structure
Notes about the Address	Free text description of address record

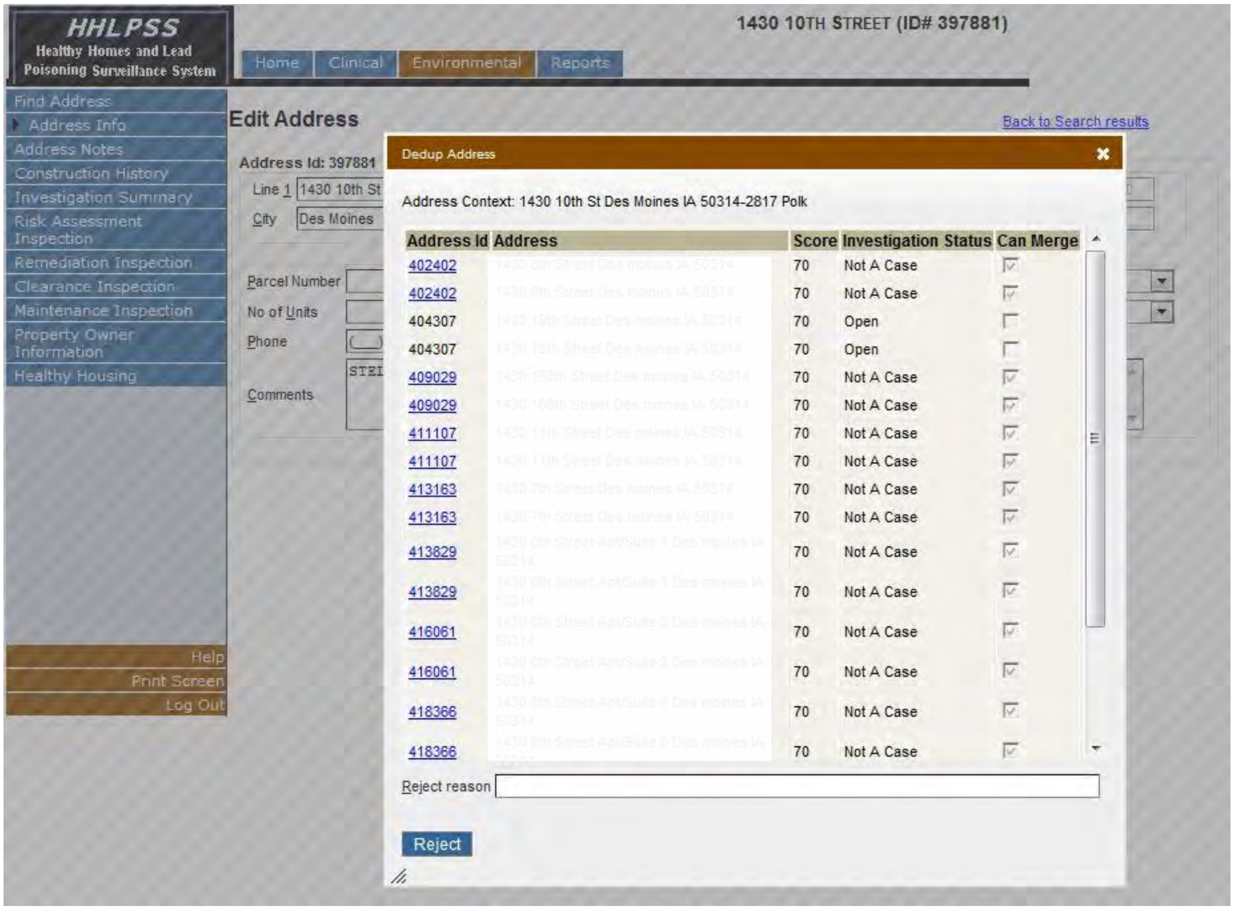
The user can edit the address details within the fields indicated in the user form. If the selected State is change the page may reload to populate the county list control.

To begin saving changes to the address record, click the "Validate Address" button beneath address details form. Address validation attempts the correction of any missing or incorrect address details and the addition of geocoding data (census block, census tract, latitude and longitude).

Once the address validation has been attempted, click the "Save Address" button will be presented to finalize the address save operation.

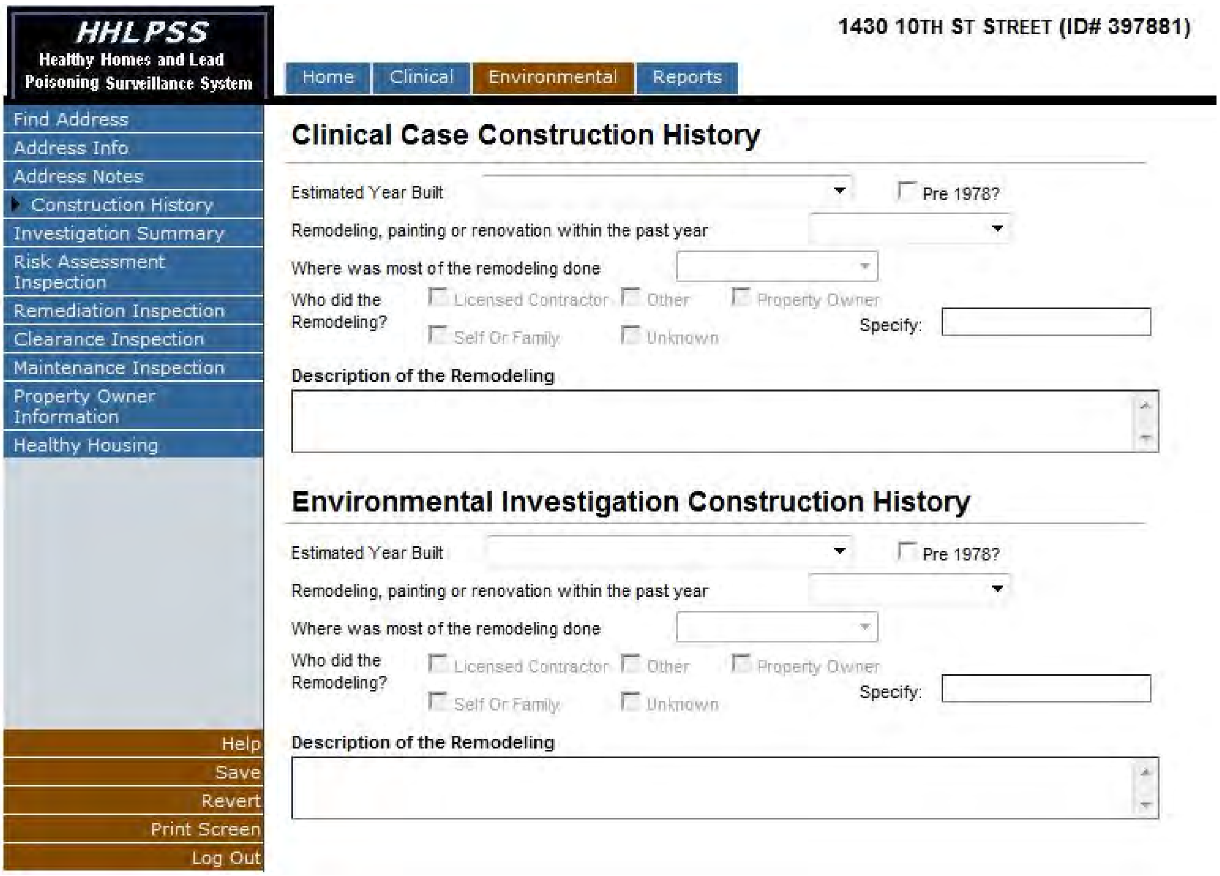
De-duplicate Address Popup

The de-duplicate address popup allows for selection or rejection of possibly matched address records. To select an existing record as a match to the newly entered record, select the address id corresponding to the matched address. If you wish to reject all possible matches and create a new address record, enter a rejection reason in the 'Reject reason' field and click the 'Reject' button.


HHLPSS
Healthy Homes and Lead Poisoning Surveillance System
1430 10TH STREET (ID# 397881)
Home
Clinical
Environmental
Reports
Find Address
Address Info
Address Notes
Construction History
Investigation Summary
Risk Assessment Inspection
Remediation Inspection
Clearance Inspection
Maintenance Inspection
Property Owner Information
Healthy Housing
Help
Print Screen
Log Out
Edit Address
Back to Search results
Address Id: 397881
Line 1
1430 10th St
City
Des Moines
Parcel Number
No of Units
Phone
Comments
Dedup Address
Address Context: 1430 10th St Des Moines IA 50314-2817 Polk
Address Id
Address
Score
Investigation Status
Can Merge
402402
70
Not A Case
402402
70
Not A Case
404307
70
Open
404307
70
Open
409029
70
Not A Case
409029
70
Not A Case
411107
70
Not A Case
411107
70
Not A Case
413163
70
Not A Case
413163
70
Not A Case
413829
70
Not A Case
413829
70
Not A Case
416061
70
Not A Case
416061
70
Not A Case
418366
70
Not A Case
418366
70
Not A Case
Reject reason
Reject

Construction History

To view or update data related to the addresses construction history, login to HHLPSS, select the Environmental Tab, and click the “Construction History” menu item of the Environmental Tab menu.



The “Construction History” page allows for the management of construction history data for an address as collected during clinical case management and environmental investigations.

If you are entering construction details as a result of data gathered for case management, input the details in the “Clinical Case Construction History” area (top half of form).

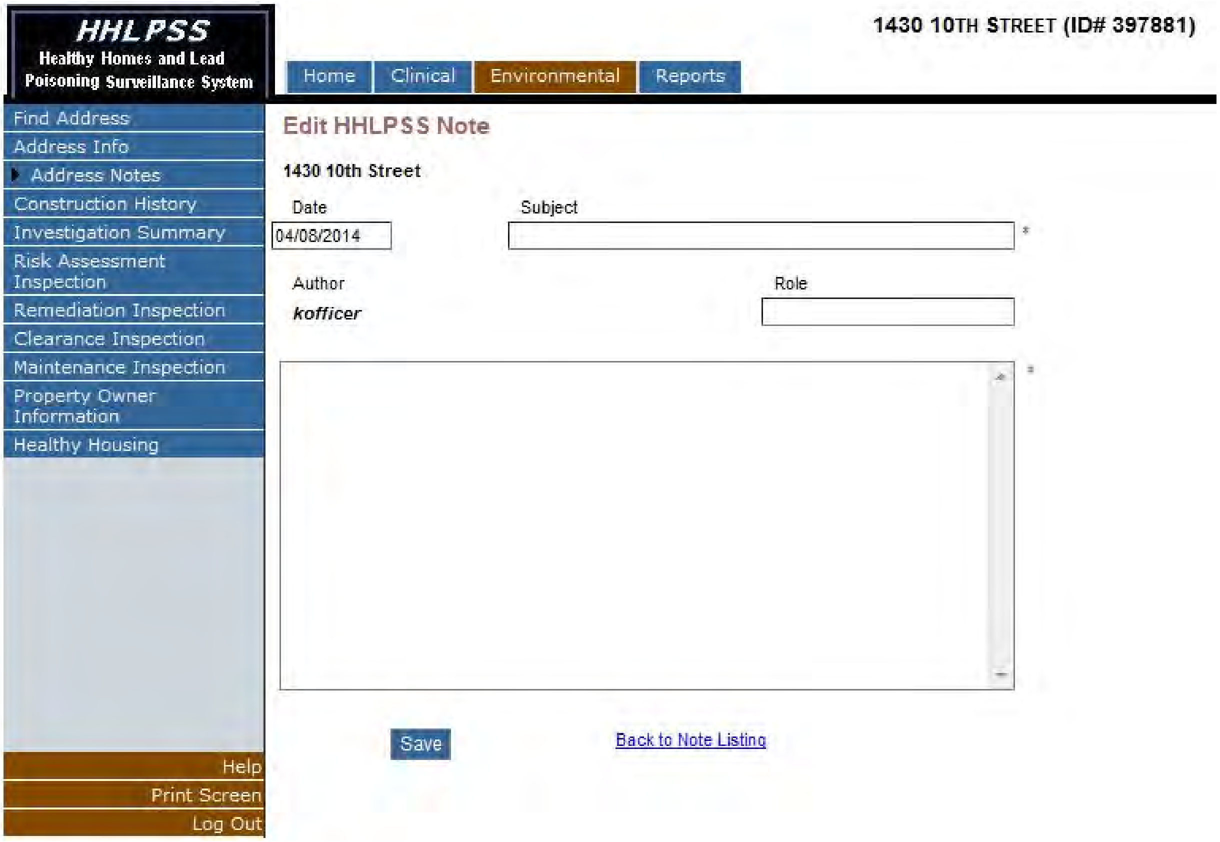
If you are entering construction details as a result of data gathered during an environmental investigation, input the details in the “Environmental Investigation Construction History” area (bottom half of form).

Address Notes

The “Address Notes” page allows the user to create custom free text notes which are associated with the address record.

Existing address notes will be listed within the Notes listing. To view or edit the details, click the “Detail” link in the “Details” column of the Notes Listing.

To add a new note to the note listing, click the “New” button in the (burgundy) bottom left corner menu to prepare the form for note creation.



The minimum fields required to create a patient record are display with a red asterisk [*] and are Date, Subject, Author, and the actual contents of the note.

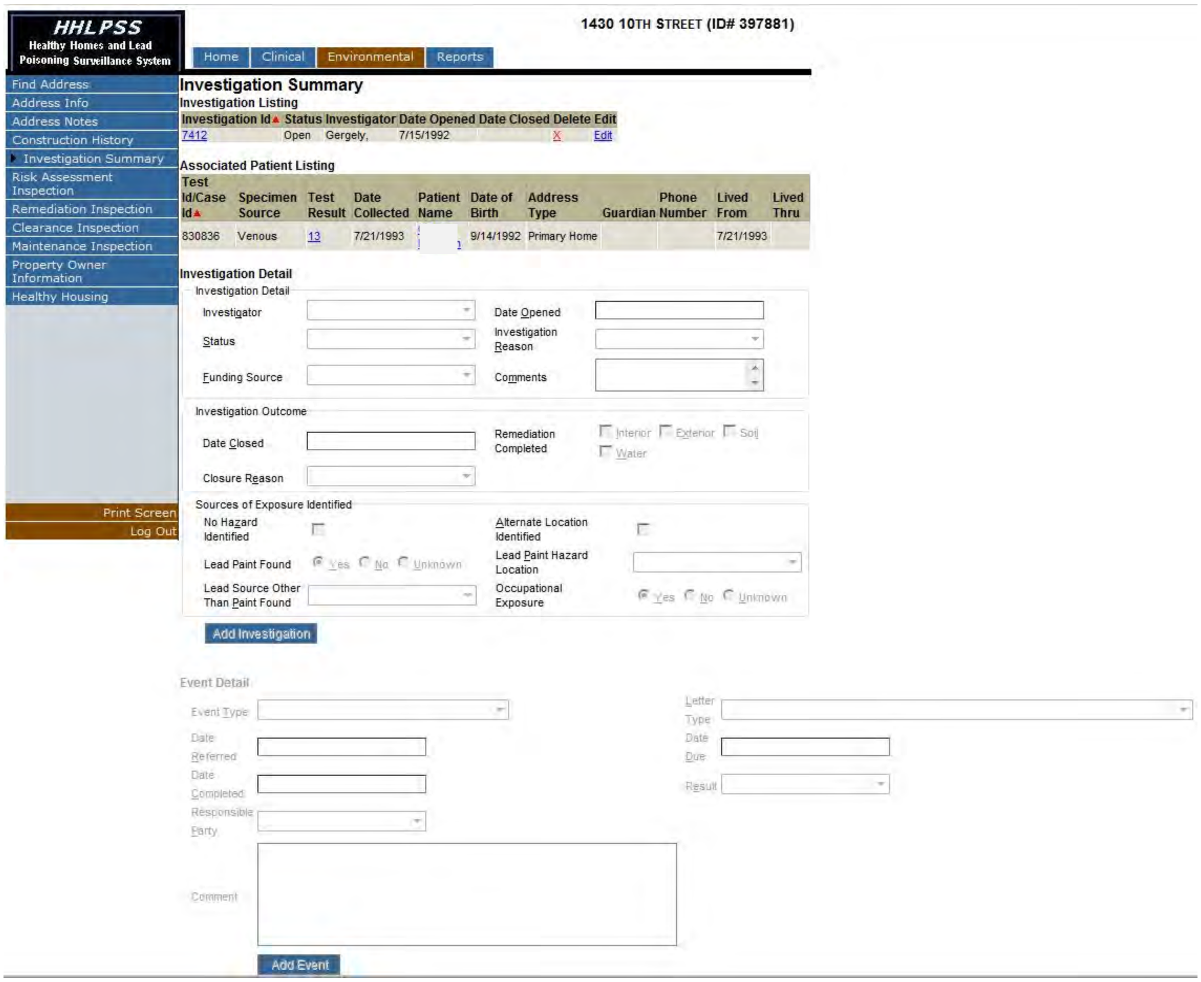
Input the corresponding data in the required and other fields corresponding to the new patient note and click the "Save" button below the note text box to save the new address note. After note creation, the note is added to the listing.

To cancel note entry and return to the address note listing, click the 'Back to Note Listing' button.

View Environmental Investigation Details

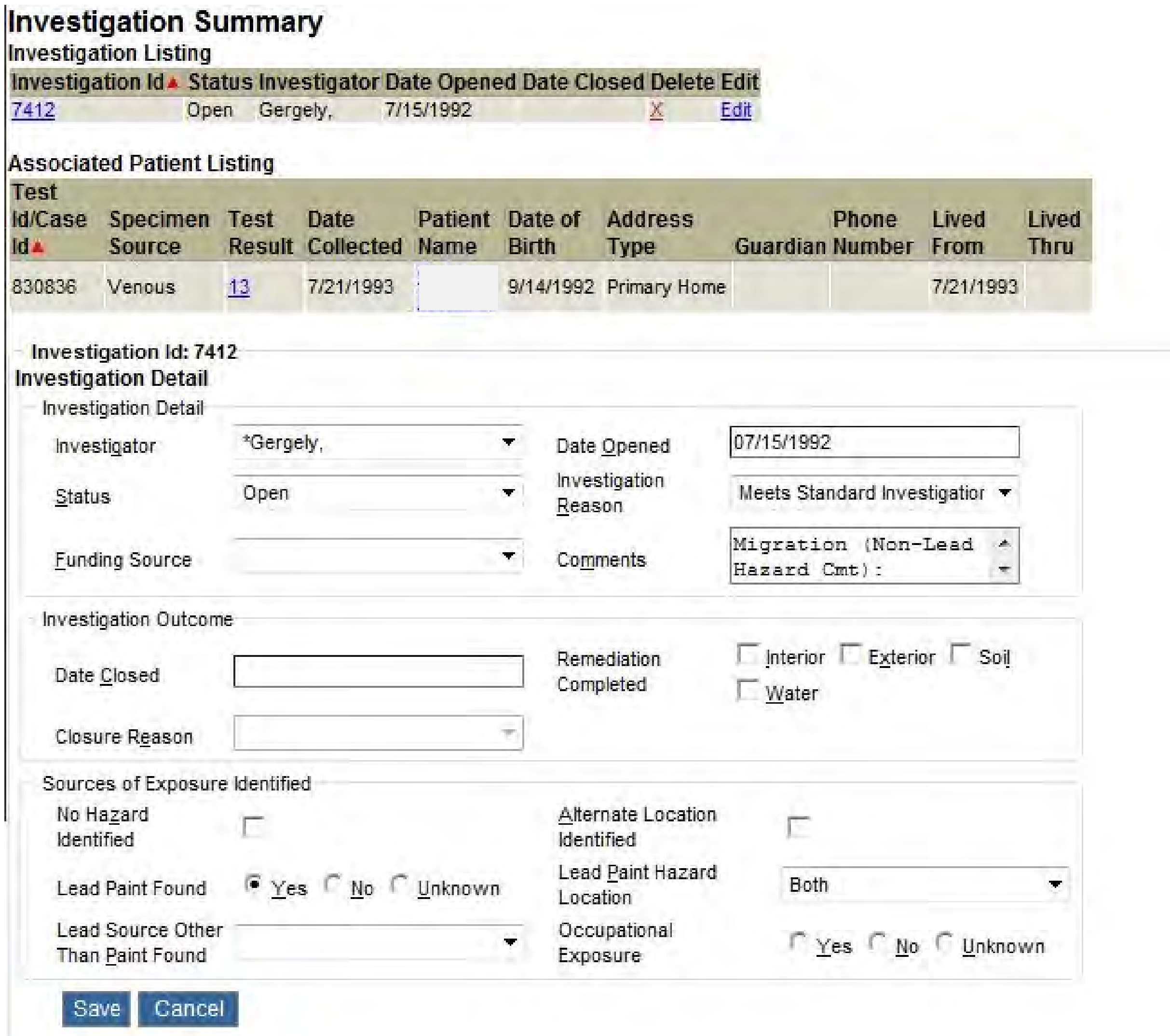
To view the details of a environmental investigation for an address, login to HHLPSS, select the Environmental Tab, and click the "Investigation Summary" menu item of the Environmental Tab menu.

Investigation Summary



The "Investigation Summary" page allows for the viewing and editing of investigation details for the currently selected address.

Select an “Investigator” to assign an environmental investigator to manage the investigation. Select a “Date Opened” to indicate the date the investigation was opened and a investigation “Status” and “Investigation Reason.” Click the “Add Investigation” button to finalize the creation of the investigation.



As the investigation progresses, additional details can be entered until closure.

To close an investigation, enter a “Date Closed” in the corresponding text box and select a “Closure Reason” from the list of possible choices.

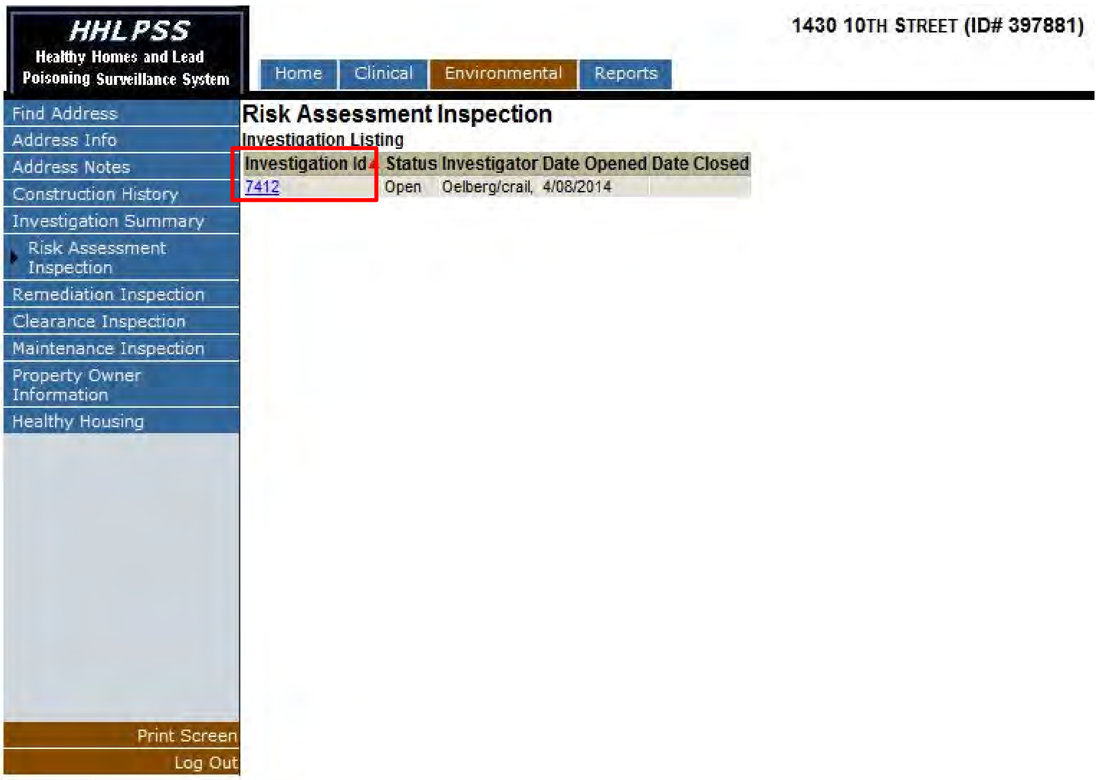
Click “Save Investigation” to finalize investigation closure.

Many pages related to Environmental Investigations within the system collect data related to environmental samples and investigation events. These areas will behave similarly across all pages.

Risk Assessment

The “Risk Assessment” Inspection page is utilized to capture the details of the risk assessment phase of the environmental investigation.

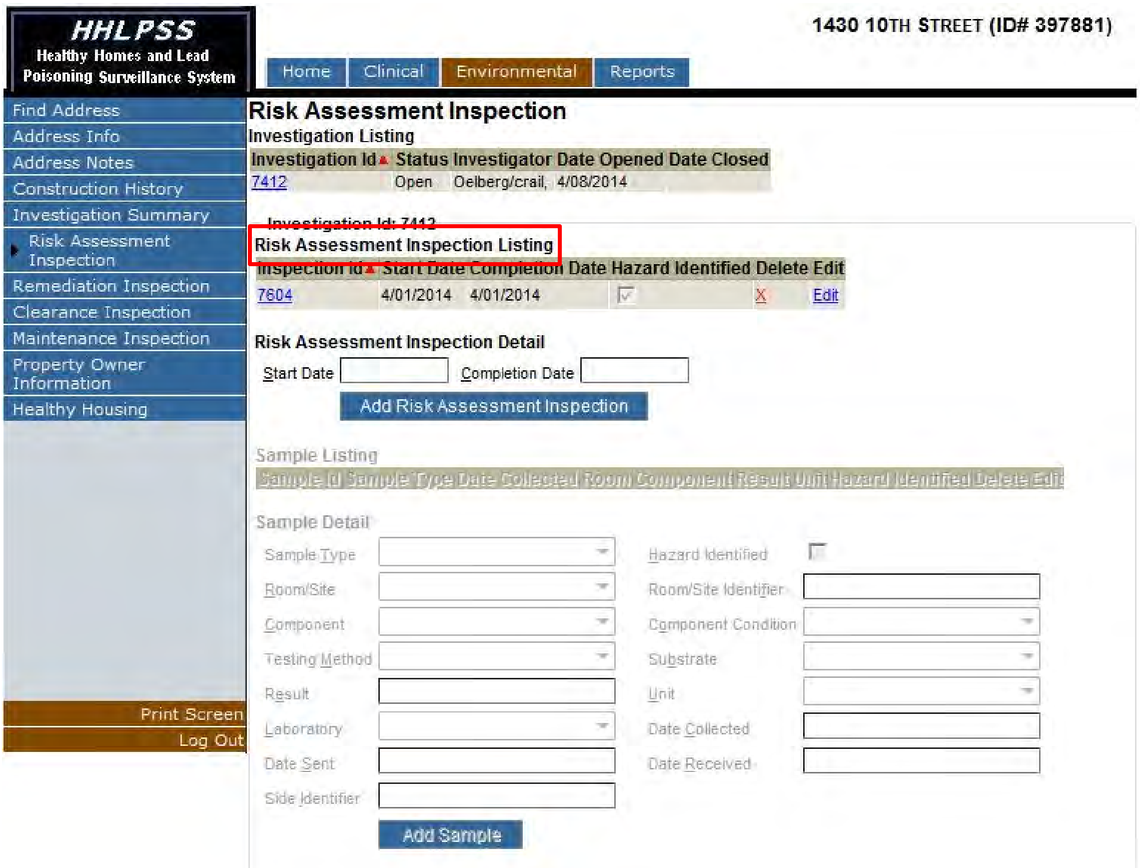
To view the details of a Risk Assessment click the “Investigation ID” in the Investigation Listing near the top of the page.



This will enable the page and grant access to the Risk Assessment Inspection Listing. To view the details or samples related to a risk assessment, click its “Inspection ID” in the Risk Assessment Inspection Listing.

View the dates associated with the inspection and the samples collected in the form below the inspection listing.

To add a new Risk Assessment input the “Start Date” and click the “Add Risk Assessment Inspection” button.



Samples identified as hazardous during a risk assessment will create remediation activities corresponding to the Room and Component where the sample was collected to ensure hazard remediation.

Remediation Activities

The “Remediation Activities” page is utilized to track activities intended to remediate hazards identified during the Risk Assessment and the contractor or individual which performs these activities.

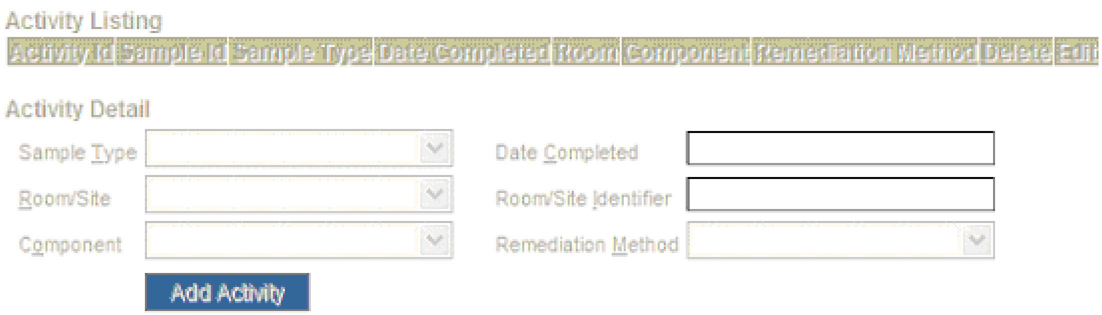
To view Remediation Activity details, click the “Investigation ID” in the Investigation Listing near the top of the page.

This will enable the page and grant access to the Remediation Activities Listing. To view the details or samples related to a remediation activity, click its “Inspection ID” in the Remediation Activities Listing.

Remediation Activities are created and linked to every Risk Assessment where hazards are identified.

Input data related to Remediation Inspection, contractor and remediation activity details and click the “Add Remediation Inspection” button to save activity inspection details.

Remediation Activities



The remediation activities user form is utilized to record activities intended to remediate hazards identified during the risk assessment.

Input the details related to the remediation activity and click the “Add Activity” button to add it to the listing.

Clearance Inspection

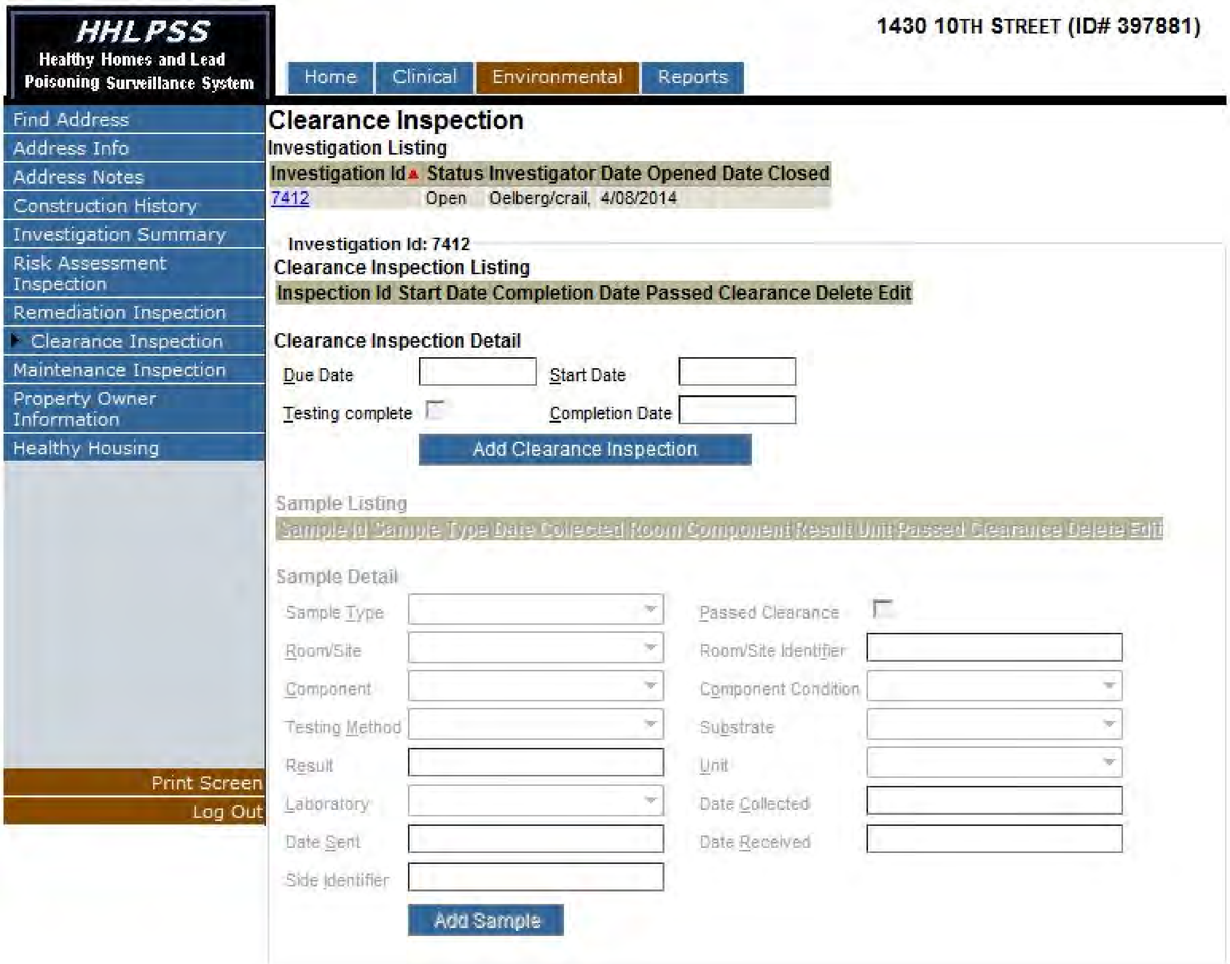
The “Clearance” Inspection page is utilized to capture the details of the clearance inspection phase of the environmental investigation.

To view the details of a Clearance Inspection click the “Investigation ID” in the Investigation Listing near the top of the page.

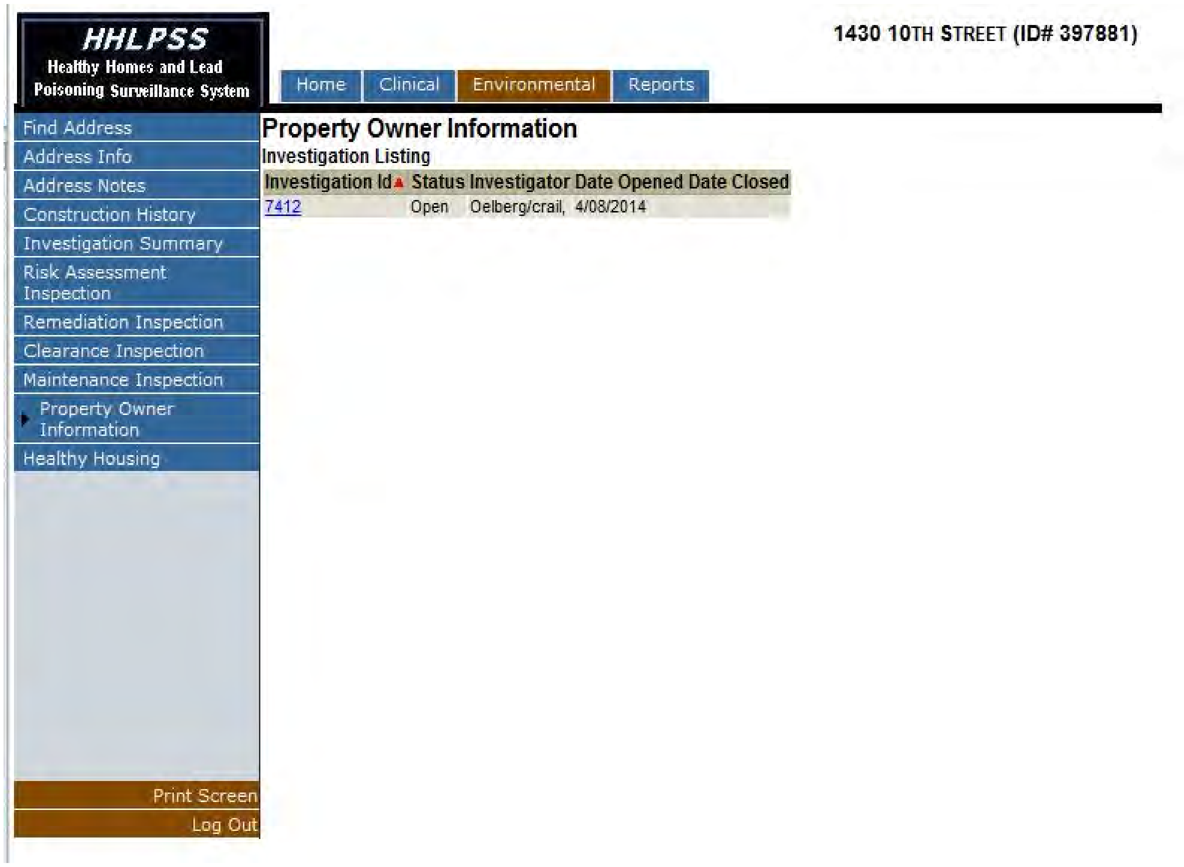
This will enable the page and grant access to the Clearance Inspection Listing. To view the details or samples related to a clearance inspection, click its “Inspection ID” in the Clearance Inspection Listing.

All environmental samples collected during a clearance inspection should meet the standard to "pass clearance" before the address is considered as "passing clearance."

Passing clearance should constitute the closure of the investigation.



Property Owner Information



The “Property Owner Information” page is utilized to capture the details related to the owner of a property undergoing an environmental investigation.

To view the property owner details of an investigation, click the “Investigation ID” in the Investigation Listing near the top of the page.

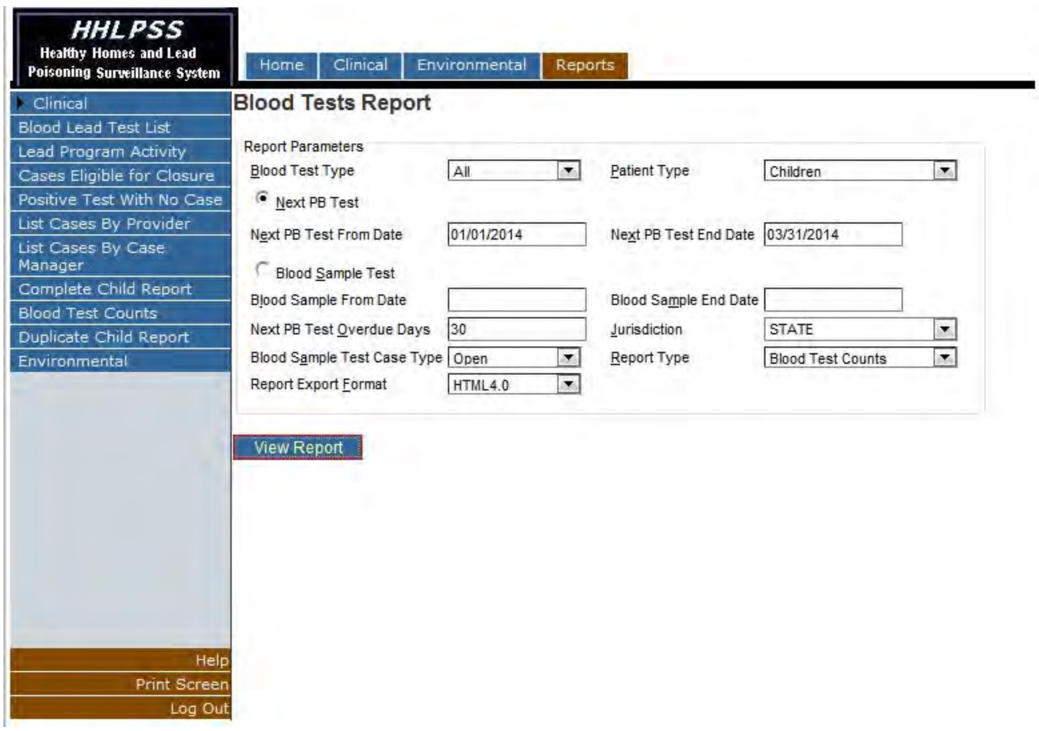
This will enable the page and grant access to the Property Owner Information user form.

Input the details related to the property owner at the time of the investigation and click the “Add Property Owner” button to save the property owner information.

HHLPSS Reports - Reports Module

From the Reports module user will be able to produce reports that provide program information on blood lead tests, inspection activity, and other activities related to the lead program.

Blood Test Reports



Lab Tests Lists

Criteria: Next PB Test Between 01/01/2014 and 03/31/2014

Date Report Generated: 05/19/2014 12:59:11 PM

Blood Test List					
Patient Name	**Date of Birth**	**Last PB**			
		Date	**Sample Source**	**Result**	**Confirmatory?**

Blood Test Counts					
Pb B Level	**Venus**	**Capillary**	**Unknown**	**Total**	**Confirmatory**
No Result	0	0	0	0	0
0-4	0	0	0	0	0
5-9	0	0	0	0	0
10-14	10	1	0	11	10
15-19	4	1	0	5	4
20-29	6	0	0	6	6
30-44	0	0	0	0	0
45-69	1	0	0	1	0
5-69	0	0	0	0	0
>=70	0	0	0	0	0
Total	21	2	0	23	20

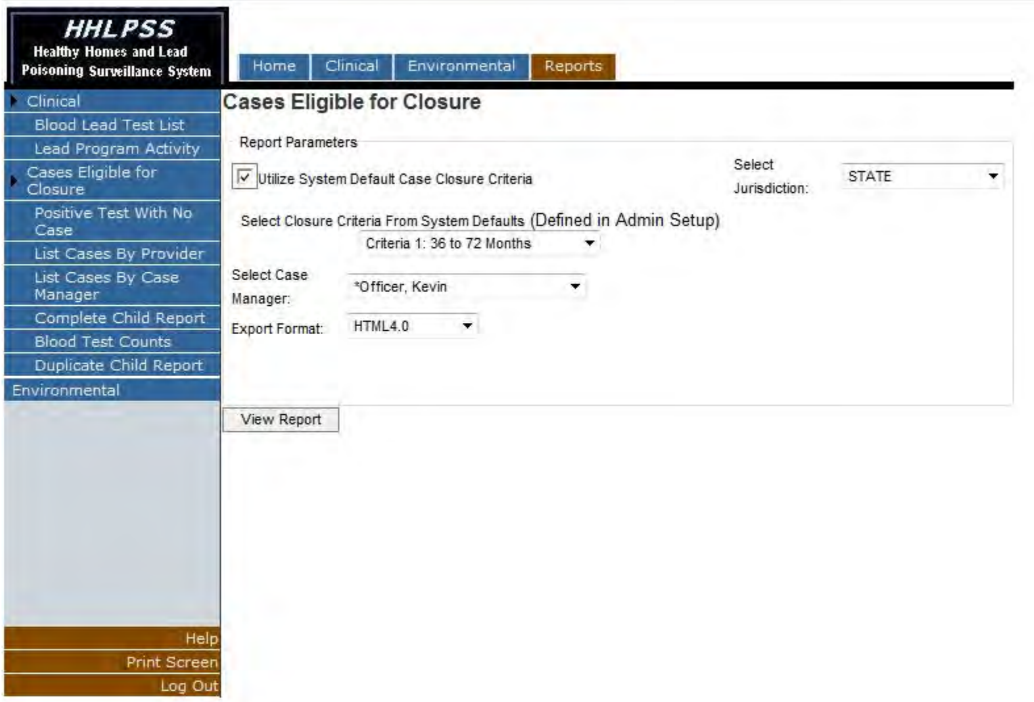
Page 1 of 1

Lead Program Activity Report

Lead Program Activity Report
Activity between 01/01/2014 and 01/31/2014
Jurisdiction: STATE
Date Report Generated: 05/19/2014 01:33:28 PM

Lab Test Results	
ELRs Completed	0
ELRs Held for Review	0
Manual Lab Test Results Entered	581
Total Number of Lab Test Results	581
Summary of Lab Test Results	
PB Level	
No Result	9
0-4	398
5-9	171
10-14	1
15-19	1
20-29	0
30-44	1
45-69	0
>=70	0
Total	581
Individual Cases	
Individual Cases Automatically Opened	0
Individual Cases Manually Opened	17
Total Number of Individual Cases Open	17
Environmental Investigations	
Environmental Investigations Automatically Opened	0
Environmental Investigations Manually Opened	2
Total Number of Individual Cases Opened	2

Cases Eligible for Closure



05/19/2014

Cases Eligible for Closing Report

10 PbB Level or Less

Query: None

Case Manager: Officer,Kevin
Name: [redacted] **Laith**   Date of Birth: [redacted]2008   HHLPSS ID: [redacted]
Address: 217 S Olive St, [redacted] Iowa [redacted]
Guardian: [redacted] Jessica
Phone: Alternate Phone:

Recent Blood Test Results

Sample Date	Type	PbB Result	Confirmatory?
9/30/2013	Capillary	6.00	False
5/5/2011	Capillary	10.00	False

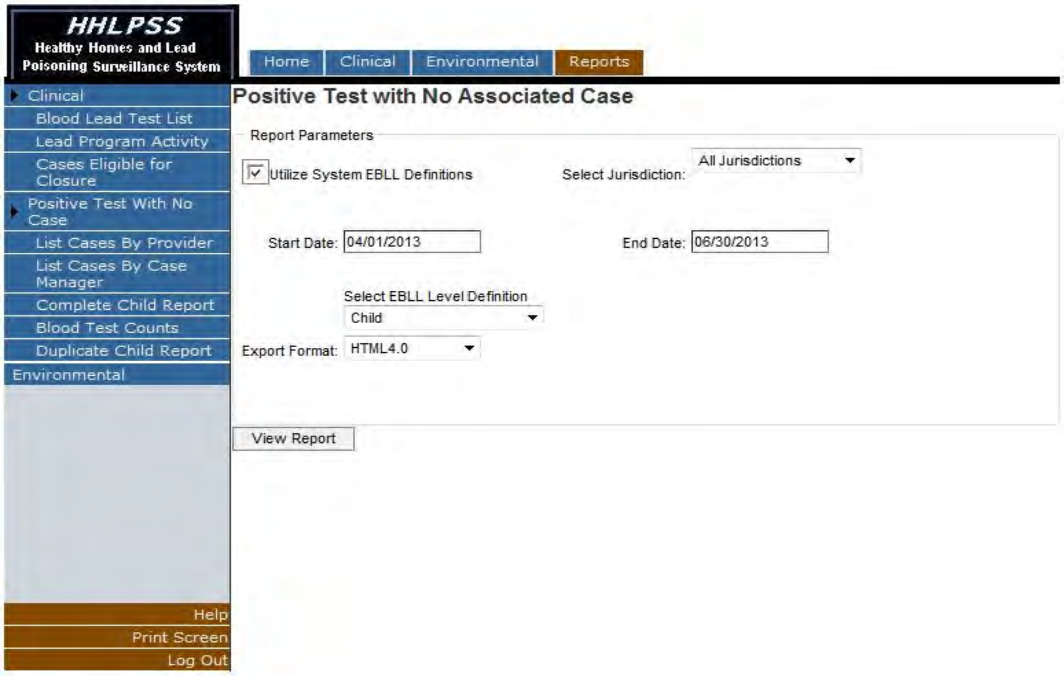
Case Manager: Officer,Kevin
Name: [redacted] **Zachary**   Date of Birth: [redacted]2009   HHLPSS ID: [redacted]
Address: 810 Broad St, [redacted]
Guardian: [redacted], Brittany
Phone: Alternate Phone:

Recent Blood Test Results

Sample Date	Type	PbB Result	Confirmatory?
9/24/2012	Venous	6.00	False
2/27/2012	Venous	7.00	False

Page 1 of 1

Positive Test with No Associated Case



05/19/2014

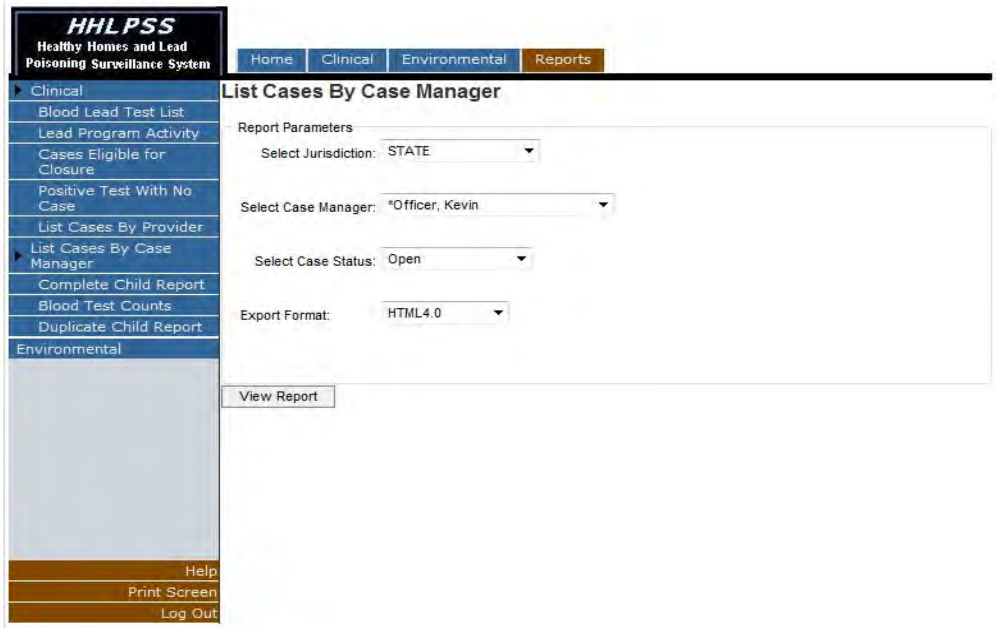
Non-case Children with PbB of 10 or greater

Tested between 4/1/2013 and 6/30/2013

Query Applied: None

		Eleveated PbB				Next PbB after Eleveated PbB			
Child	Date of Birth	Level	Type	Date	Conf.?	Level	Type	Date	Conf.?
Angel, Brandon	3/4/2009	12.00	BLDC	4/4/2013	N	None			
Arambula, Bryanna	11/29/2011	11.00	BLDC	4/11/2013	N	None			
Araujo, Kimberly	3/12/2012	12.00	BLDC	4/4/2013	N	None			
Armenta, Kelen	5/12/2011	12.00	BLDC	6/7/2013	N	None			
Asmus, Carlos	1/8/2008	10.00	BLDC	6/5/2013	N	None			
Castro Ramirez, Adriana	6/26/2009	10.00	BLDC	5/20/2013	N	None			
Dolash, Addyson	4/16/2012	10.00	BLDC	5/2/2013	N	None			
Espinoza, Alyssa	2/13/2009	10.00	BLDC	4/16/2013	N	None			
FLORESLERA, YAKELIN	6/16/2008	15.00	BLDC	4/4/2013	N	None			
Fonseca, Chelsy	4/26/2010	11.00	BLDC	4/4/2013	N	None			
Fonseca, Idaly	12/14/2009	12.00	BLDC	4/4/2013	N	None			
Garcia, Jovani	3/25/2011	10.00	BLDC	4/8/2013	N	None			
Gentry, Kristopher	8/4/2009	15.00	BLDC	4/2/2013	N	11.00	BLDV	6/7/2013	N
Gutierrez, Joselyn	7/29/2008	22.00	BLDC	4/25/2013	N	None			
Juarez, David	3/22/2009	13.00	BLDC	4/16/2013	N	None			
Leonard, Jaxon	5/20/2012	39.00	BLDC	5/16/2013	N	None			
Moore, Nevin	12/29/2011	10.30	BLDC	6/25/2013	N	None			
Morrison, Sebastion	5/24/2012	11.00	BLDC	6/19/2013	N	None			
Ramirez, Arisbeth	3/8/2012	15.00	BLDC	4/18/2013	N	None			
Ramirez, Brian	4/13/2010	10.00	BLDC	6/27/2013	N	None			
SANCHEZ, ITZEL	9/13/2011	11.00	BLDC	4/9/2013	N	None			
Sang, Van	5/23/2009	10.00	BLDC	5/28/2013	N	None			

List Cases By Case Manager



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Case Children, Sorted By Case Manager

Includes Open case status

Query Applied: None

Case Manager: Officer,Kevin

Child/Guardian	Date of Birth	Confirmed Date	Confirmed Level	Most Recent PbB Date	Most Recent PbB Level	Most Recent PbB Type	Previous PbB Date	Previous PbB Level	Previous PbB Type
Barton, Donald III	6/12/2007	8/24/2010	20.00				1/10/2011	24.00	V
Guardian: Ostrander, Alizah		5633867432					Status O		
Blair, Jayden	9/20/2008	11/23/2010	24.00				12/19/2011	28.00	C
Guardian: Blair, Jacob		No phone number given					Status O		
Ensz, Blake	1/31/2009	2/8/2013	33.00				2/5/2013	31.00	V
Guardian: Ensz, Alyssa		No phone number given					Status O		
Ensz, Judson	11/16/2011	2/8/2013	50.00				2/6/2013	48.00	V
Guardian: Ensz, Sam		No phone number given					Status O		
Grady, Reis	9/28/2011	11/8/2013	21.00	11/8/2013	21.00	V	11/8/2013	21.00	V
Guardian: Grady, Tiara		No phone number given					Status O		
Hackley, Caelon	2/25/2007	3/19/2009	38.00	9/10/2009	15.00	C	7/6/2009	14.00	V
Guardian: Schultz, Josephine		No phone number given					Status O		
Leroy, Kaelynn	5/3/2010	11/21/2011	41.00				1/6/2012	25.00	V
Guardian: Leroy, Megan		No phone number given					Status O		
McClaren, Michael	7/1/2012	8/16/2013	20.00				8/16/2013	19.00	V
Guardian: McClaren, Kelly		No phone number given					Status O		
Meyer, Alden	5/5/2010	2/9/2012	27.00				2/12/2013	19.00	V
Guardian: No guardian named		No phone number given					Status O		
Miller, Clara	12/19/2007	6/26/2009	23.00	8/17/2010	12.00	V	7/20/2010	15.00	C
Guardian: Miller, Clara		No phone number given					Status O		
Morris, Paul	6/2/2011	7/9/2012	18.00				3/18/2013	12.00	C
Guardian: Morris, Amanda		No phone number given					Status O		